

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, this medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 22859				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 7:00 AM	
			LUELLA	M.	BAILEY	September 21, 1983					
3. SEX Female			4. RACE White	5. DATE OF BIRTH July 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany				MD.	
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Med. Cntr.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE W.Va.			13b. COUNTY Mineral	13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Chandell St. 9999 Keyser	
14. FATHER'S NAME FIRST Edward MIDDLE Wright LAST Bailey			15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE Catherine LAST Shoemaker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 235 52 5319			17. INFORMANT Alahmae Shoemaker				ADDRESS Burlington, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8880			CEREBRAL & BRAIN STEM CORTICAL CELEBRIAL DUE TO, OR AS A CONSEQUENCE OF Contusions							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {			(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 17 18 19 3			21c. HOW INJURY OCCURRED Fell				(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nursing Home			21f. LOCATION STREET Heartland Nursing Home, Keyser, W.Va.				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE August A. Figueroa			22c. DEGREE Medical Building			22d. DATE SIGNED 21 Sept 83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Figueroa			23c. NAME OF CEMETERY OR CREMATORIAL Beaver Run Cemetery			23d. LOCATION CITY OR TOWN Burlington				23e. COUNTY Mineral	23f. STATE W.Va.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 24 Sept 83			23d. LOCATION CITY OR TOWN Burlington				23e. COUNTY Mineral	23f. STATE W.Va.
24. FUNERAL DIRECTOR NAME Allen Rotruck			24. FUNERAL DIRECTOR NAME Keyser, W.VA.			25a. DATE REC'D. BY REGISTRAR SEP 28 1983				25b. REGISTRAR'S SIGNATURE Glenda Canfield	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8-5 22860	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
	Marie	Margaret	Barnard	September 21, 1983				9:55 A			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		
Female	White	Dec. 1, 1912			70 YRS.				IF UNDER 24 HRS		
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 505 Central Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 505 Central Avenue				
14. FATHER'S NAME FIRST William MIDDLE Senkbeil LAST		15. MOTHER'S MAIDEN NAME FIRST Eleanora MIDDLE S. Smith LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --			17. INFORMANT Betty L. Crowding			ADDRESS 1527 Constitution A- Woodlyn, PA 19094			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diseases</i> .										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchio-alveolar Cell Disease</i> } DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>9-9-83</i> , to <i>9-9-83</i> , that (I) (we) last saw the deceased alive on <i>9-9-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>9-21-83</i>	
22b. SIGNATURE <i>Dr. James W.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Uriel Velandia, M.D., P.A.</i>			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-23-83		23c. NAME OF CEMETERY OR CREMATORIAL St. Lukes Cemetery			23d. LOCATION CITY OR TOWN Cumberland COUNTY Allegany MD				
24. FUNERAL DIRECTOR NAME Leasure Stein Funeral Home, Inc. 230 Baltimore Ave.		25a. DATE REC'D. BY REGISTRAR SEP 27 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conigli</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 22861				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		Robert Leo Bauman			Sept. 10, 1983					2:20 P		
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male		White		Jan. 3, 1936					49		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA						Allegany MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland		31 West Roberts St.		Construction		Local						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland			31 West Roberts St.							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Charles R. Bauman				Edith Cunningham								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
No		236-48-2976		Mrs. Stella Bauman, Cumberland, Md. Wife								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				CARCINOMA OF ESOPHAGUS, mid-Third with Metastasis								
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DOUE TO, OR AS A CONSEQUENCE OF (b)												
DOUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION 12/28/82.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF ESOPHAGUS.				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/28/82 to 9-10-83, that (I) (we) last saw the deceased alive on 8/26/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Calvin Y. Hadidian		DEGREE M.D.		ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/12/83.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Cumberland, Memorial Hospital Medical Bldg., Md.								
Dr. Calvin Y. Hadidian M. D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-13-83		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial				Monnett Cemetery		Near Short Gap, W. Va.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE								
James F. Scarpelli, Cumberland, Md.				SEP 15 1983 John J. Connelly								



... Basfrode, 11. Oct. 1900.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22662		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
Mariom D Beck						<input checked="" type="checkbox"/> 9 4 19 83			3P M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	May 26, 1914			69 yrs.	MONTHS	DAYS	MONTHS	DAYS	HOURS	MIN.	9 7 19 83	6P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA						Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			619 Leiper St.			Retired			Labor Union					
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			MD.		
Maryland			Allegany			Cumberland			619 Leiper St. 21502					
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST					
Louis H. Beck						Nellie S. Robinette								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			214-07-6011			Mr. Danny Lou Beck, Cumberland, Md. Son								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 9-7-83		
ACTUAL SIGNATURE <u>Francisco Reyes</u>			M.D.			TITLE (SPECIFY) <u>Deputy</u>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			Dr. Francisco Reyes, M. D.			ADDRESS			Sacred Heart Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-9-1983			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION CITY/TOWN Cumberland, Allegany, Md.			COUNTY		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR James F. Scarpelli, Cumberland Md. 21502 SEP 15 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Caneff</u>					

April 20th

G#583 9/20/83 mtb Items 18-22a

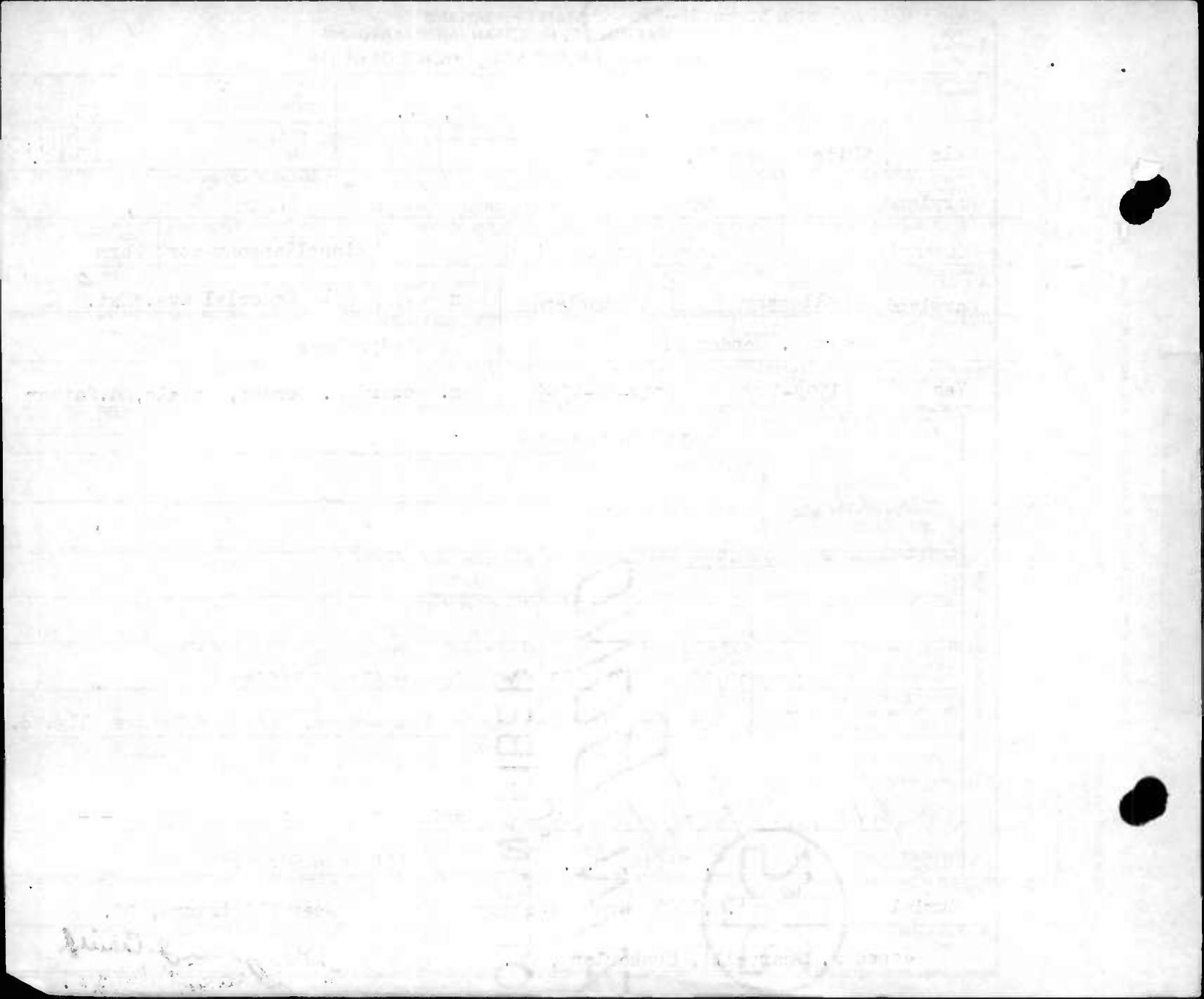
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22863

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Howard			M.	Bender, Jr.	<input checked="" type="checkbox"/>	9	2	1983		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	May 14, 1956	27			9	2	1983	11:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Allegany County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Sacred Heart Hospital				Miscellaneous Work		Farm		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Allegany		Cumberland				31 Memorial Ave. Ext. 21502		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		
Howard M. Bender II						Gladys Dyer		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		1972-1973		217-66-9999		Mr. Howard M. Bender, LaVale, Md. Father				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8820 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 10:30 A.M. 9/2 1983 Fell from railroad bridge						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Potomac River bed		21f. LOCATION STREET under Western md. Railroad Bridge Allg.Md.		CITY OR TOWN			COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant M.D.			MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)									DATE SIGNED 9-3-83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN Near Flintstone, Md.		COUNTY STATE	
Burial		Sept. 6, 1983		Rush Cemetery						
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli,		Cumberland, Md.				SEP 9 1983		John J. Smith		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

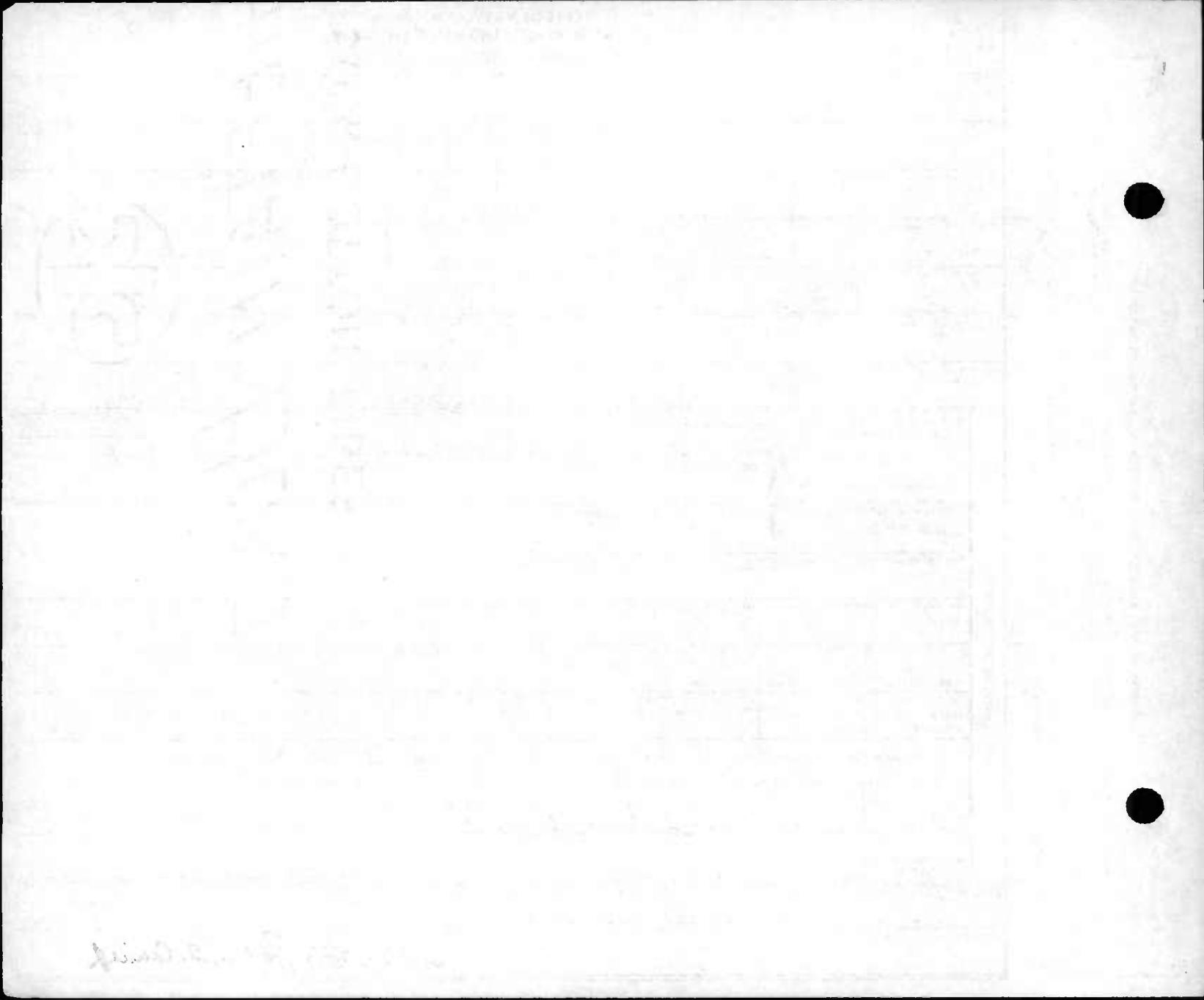
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22864					
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR					
JAMES EDWARD BENNETT						AUGUST 22, 1983						2:09					
1. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			M					
Male			White			July 7, 27			56			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. X MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA									Allegany MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL									Military			Retired		
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 709 Elm Street, 21502					
14. FATHER'S NAME Otis C. Bennett, Sr.			15. MOTHER'S MAIDEN NAME Mary Cecilia McGowan														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NW 11/Korea 215-20-5454			17. INFORMANT			ADDRESS			21502					
Yes						Betty Lee Bennett, Cumberland, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischaemic cardiomyopathy</u> (c) <u>Coronary Artery Disease</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CVA, vascular disease, Hyperkalemia</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> , to <u>8/22 1983</u> , that (I/we) last saw the deceased alive on <u>Aug 22 1983</u> , and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Desai</u>			MD. DEGREE 8/22/83 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Desai			22e. ADDRESS Memorial Hospital Cumberland, Maryland 21502														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 25, 83			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Pk			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR William G. Kight, Cumberland, Md.						25a. DATE REC'D. BY REGISTRAR AUG 29 1983			25b. REGISTRAR'S SIGNATURE <u>John G. Kight</u>								

20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
100% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND **3 TO THE FUNERAL DIRECTOR**. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22865
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b. HOUR
Carrie Catherine Billmyer						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	16	1983	a.m. 2:30
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Female	White	Jan 1 1894	89 yrs.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	16	1983	m
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Ohio		U.S.A.						Allegany MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		216 Cecelia Street			Housekeeper							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Allegany	Cumberland				216 Cecelia Street					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST					
Louis			Borchert	Catherine			Dreyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No		215-48-4874			Mrs. Robert Hayes			2980 Cedar Hill Road Cuyahoga Falls, Ohio				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Giovanni Mastrangelo			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER				DATE SIGNED
EXAMINER'S NAME (TYPE OR PRINT)												9/16/83
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		Sept 19/83		Hillcrest Burial Park			Cumberland		Allegany	Maryland		
24. FUNERAL DIRECTOR NAME		ADDRESS		404 Decatur St			25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service		Cumberland, Md		SEP 20 1983								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

#6, FilmG584 10/31/83 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

EDT

1 - FOR
STATE
REGISTRAR

REG. NO.

8 5 2 2 8 6 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE LENORE	LAST BLOOM	2a. DATE OF DEATH SEPTEMBER 20, 1983	MONTH DAY YEAR	2b. HOUR 711 PM
3. SEX Female			4. RACE White	5. DATE OF BIRTH May 12, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 83 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1602 Ebbotts Place
14. FATHER'S NAME Joseph			MIDDLE L.	LAST Haldeman	15. MOTHER'S MAIDEN NAME Olive		LAST Demoss	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 232-96-1515			17. INFORMANT 1602 Ebbotts Place Harold Bloom, Crofton, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b). Helen clente (Heart disease) DUE TO, OR AS A CONSEQUENCE OF (c). Helen clente								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (We) attended the deceased from say the deceased olive on above. (I) (We) did not view the body after death.		22b. DATE 19 19		22c. DATE 19 19		22d. DATE SIGNED 9/20/83		
22e. SIGNATURE JORGE B. RAMIREZ, M.D.		22f. DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. ADDRESS 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061		22h. DATE SIGNED 9/20/83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-24-83		23c. NAME OF CEMETERY OR CREMATORIAL Woodsdale Memorial PK.		23d. LOCATION CITY OR TOWN Grafton, Taylor, W. Virginia		
24. FUNERAL DIRECTOR NAME Beall Funeral Home,		24b. ADDRESS 16000 Annapolis Road Bowie, Maryland 20715		24c. DATE REC'D. BY REGISTRAR SEP 23 1983		24d. REGISTRAR'S SIGNATURE John G. Lohuis		



1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BOALS FUNERAL HOME LONACONING, MD 21539			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			83 22861								
FOR STATE REGISTRAR						REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MAGGIE		C.		BROADWATER				SEPTEMBER 30, 1983				1:50 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH MAY		DAY 10		YEAR 1903				6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? ISA		8		MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY						WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>				MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		
13a. STATE MD		13b. COUNTY ALLEGANY		13c. CITY OR TOWN BARTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE P.O. BOX 337 21521		
14. FATHER'S NAME FIRST HUGH		MIDDLE L		LAST BRADSHAW		15. MOTHER'S MAIDEN NAME FIRST ELLAR		MIDDLE				LAST THOMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239 09 7955		17. INFORMANT RUSSELL BROADWATER P.O. BOX 337 BARTON, MD. 21421		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2030		UREMIC SYNDROME												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 2030		DUE TO, OR AS A CONSEQUENCE OF, Acute Renal Failure due to Hyperacute Kidney				DUE TO, OR AS A CONSEQUENCE OF, Multiple Myeloma								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pericarditis														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death		9/12 1983		to 9/30 1983		9/30 1983								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/30/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
V. RAUL FELIPA, M.D.		925 BISHOP WALSH RD., CUMBERLAND, MD. 21502												
23a. BURIAL, CREMATION, REMOVAL ISPECIFY BURIAL		23b. DATE 10/2/83		23c. NAME OF CEMETERY OR CREMATORIAL TWIN CHURCHES CEMETERY		23d. LOCATION NEW GERMANY GARRETT MD.								
24. FUNERAL DIRECTOR NAME BOALS FUNERAL SERVICE, P.A.						25a. DATE REC'D. BY REGISTRAR OCT 6 1983		25b. REGISTRAR'S SIGNATURE John J. Conroy						

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472 *Journal of Health Politics*

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222 BLOOR ST. W., TORONTO, ONTARIO, CANADA

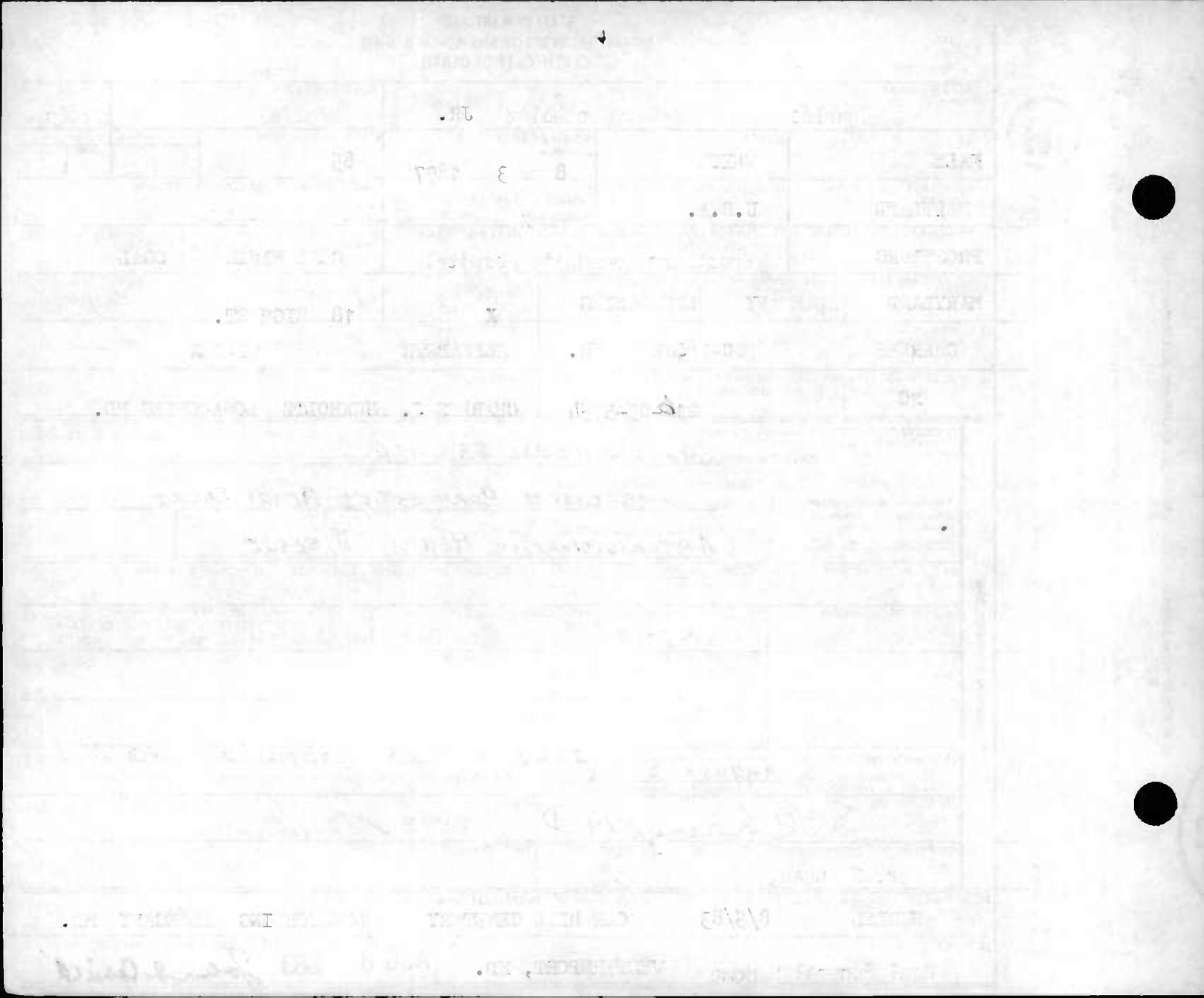
• M. D. LITTLE, M.D.

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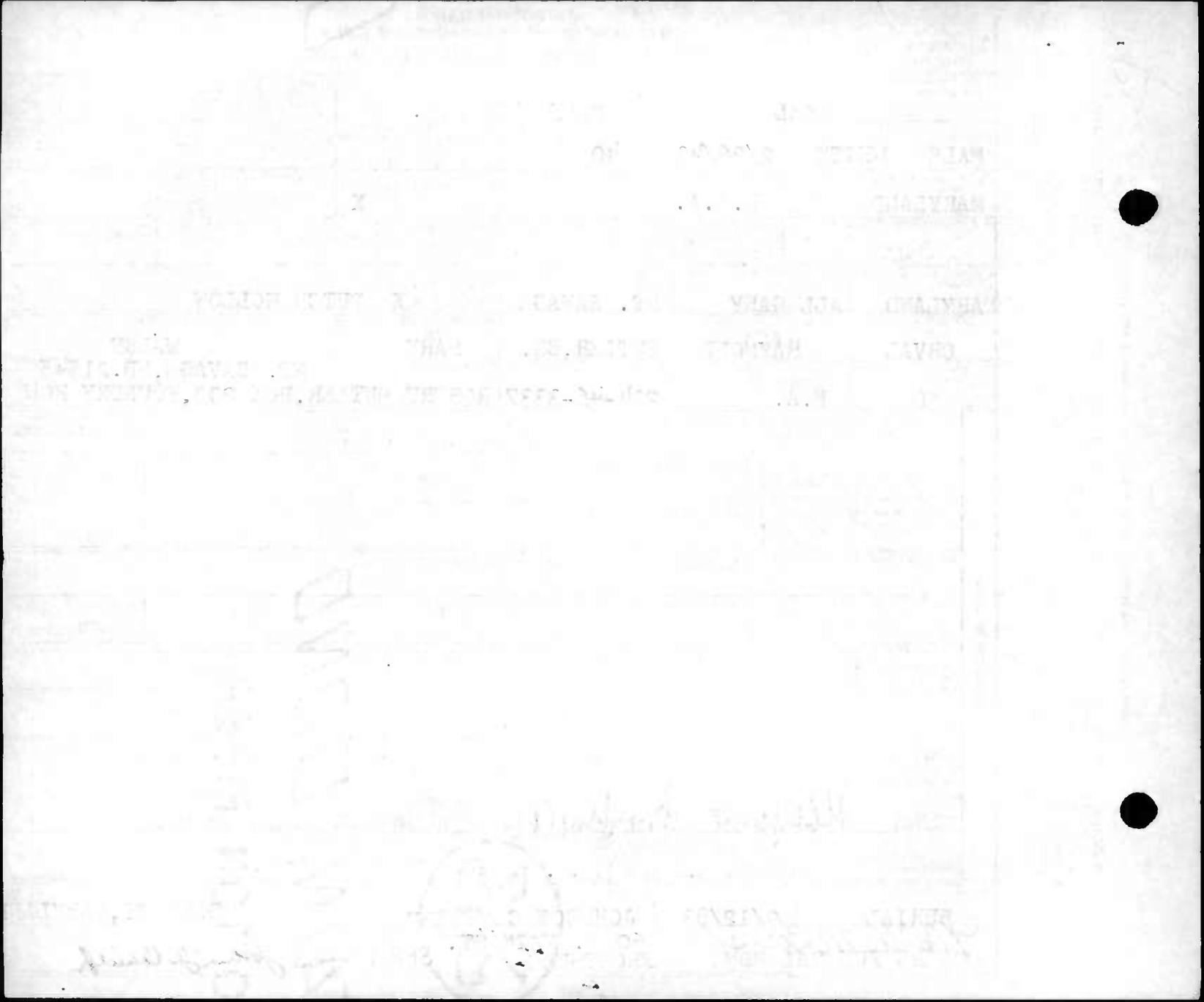
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22368			
1 - FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Charles						Buckholz JR.		8/02/83					12:40 P M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		8 3 1897		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County		MD.			
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COAL MINER		12b. KIND OF BUSINESS OR INDUSTRY COAL							
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LONACONTNG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18 HIGH ST.		21539			
14. FATHER'S NAME CHARLES		MIDDLE BUCKHOLTZ LAST SR.		15. MOTHER'S MAIDEN NAME ELIZABETH		16. SOCIAL SECURITY NO. 216-05-5754		17. INFORMANT CHARLES J. BUCKHOLTZ		ADDRESS LONACONTNG MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RENAL FAILURE</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) <u>INTRACTABLE CONGESTIVE HEART FAILURE</u> { DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 18, 1983</u> , to <u>AUGUST 2, 1983</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 2, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>S. Chang M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. S Chang</u>		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/5/83		23c. NAME OF CEMETERY OR CREMATORIUM OAK HILL CEMETERY		23d. LOCATION CITY OR TOWN LONACONTNG		COUNTY ALLEGANY		STATE MD.			
24. FUNERAL DIRECTOR NAME Boal Funeral & Home		ADDRESS WESTERNPORT, MD.		25a. DATE REC'D. BY REGISTRAR AUG 8 1983		25b. REGISTRAR'S SIGNATURE <u>John G. Cawie</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM, 3, RETAIN PAGE 5 FOR YOUR USE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22869			
1. DECEDENT'S NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
ORVAL			RAY MOND BUTLER, JR.			<input checked="" type="checkbox"/> 9-8-83			19			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 6:15P M	
MALE	WHITE	2/26/43	40			<input checked="" type="checkbox"/> 9-8-83			19			M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Allegany County			
MARYLAND		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frostburg		Rt. 3 Box 491											
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS DUTCH HOLLOW		81545			
14. FATHER'S NAME FIRST ORVAL		MIDDLE RAYMOND		LAST BUTLER, SR.		15. MOTHER'S MAIDEN NAME FIRST MARY		MIDDLE		LAST WALSH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to face with injury to neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		N.A.		214-46-3337		ROBERT BUTLER, BOX 200, FOUNDRY ROW							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 9-8-83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in a house at		21f. LOCATION STREET Rt. 3 Box 491 CITY OR TOWN Frostburg, Maryland COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margarita Korell</u> M.D. TITLE (SPECIFY) Assistant EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street										DATE 9-9-83 SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/12/83		23c. NAME OF CEMETERY OR CREMATORIUM JOHNSON CEMETERY			23d. LOCATION CITY OR TOWN GARRET, MARYLAND COUNTY STATE						
BURIAL MARGARITA A. KORELL FUNERAL DIRECTOR MARGARITA A. KORELL SOWERS FUNERAL HOME				60 W. MAIN ST. FROSTBURG			25a. DATE REC'D. BY REGISTRAR SEP 15 1983			b. REGISTRAR'S SIGNATURE <u>John J. Cauchi</u>			
DHMH - 17 (VR A15 ME (5)) 20M 4/B2													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 14 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DURST FUNERAL HOME FOR STATE REGISTRAR FROSTBURG, MARYLAND 21502 CERTIFICATE OF DEATH				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				83 22870				
								REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST		2d. DATE OF DEATH MONTH DAY YEAR				2d. HOUR
ROBERT CLARENCE CARDER								SEPTEMBER 18, 1983				12:45A
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE		WHITE		JANUARY 16, 1895		88 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY				MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINER				12b. KIND OF BUSINESS OR INDUSTRY COAL MINES				
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS BOX 510		21540		
14. FATHER'S NAME FIRST JAMES		MIDDLE B.	LAST CARDER	15. MOTHER'S MAIDEN NAME FIRST NANCY				MIDDLE	LAST ROBISON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-6303A		17. INFORMANT				ADDRESS Box 510				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock with dehydration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1419 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Ca of tracheal w/ septicemia DUE TO, OR AS A CONSEQUENCE OF (c) COPD DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-15-83 to 9-18-83 , that (II) (we) last saw the deceased alive on 9-17-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John Mehanna		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 9-22-83						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA M.D.		22g. ADDRESS 909-B SETON DRIVE CUMBERLAND MD. 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT.20,1983		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL PARK		23d. LOCATION CITY OR TOWN FROSTBURG, ALLEGANY		23e. COUNTY		STATE MD.		
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD. 21532		ADDRESS				25a. DATE REC'D. BY DEPARTMENT				25b. REC'D. BY		
25c. SEP 26 1983 Zane & Gandy												

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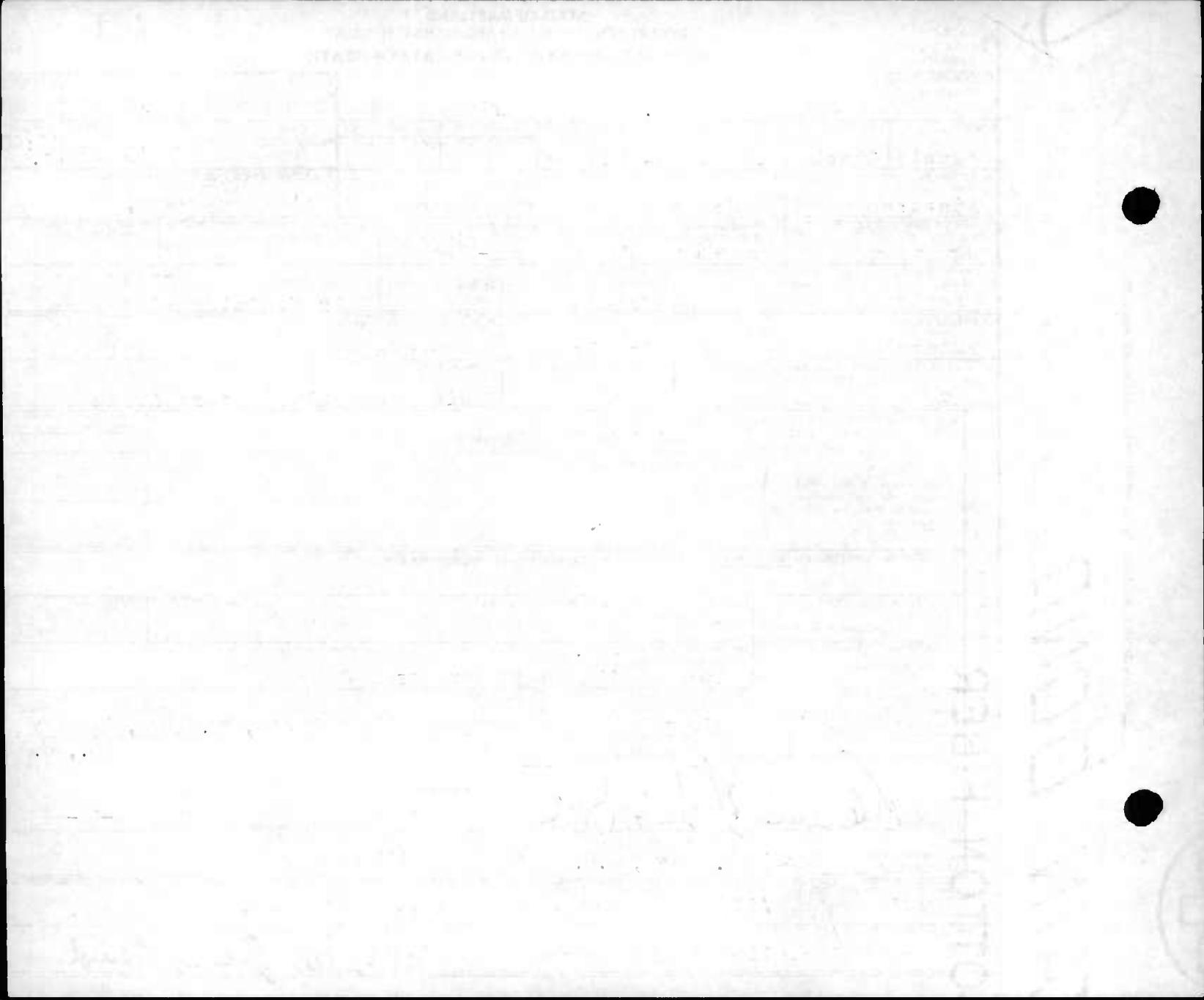
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										22871					
										REG. NO.					
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE	LAST	2a DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
		Joan A. Charlton								XX	9	11	1983		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		Black		8 16 64		19						9 13 1983		11:40 a.m.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD			
Kingston		Jamacia								Allegany County,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frostburg		Frostburg College Campus- bank													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES XX NO		13e. STREET ADDRESS		21215					
Maryland				Baltimore		XX		2829 W. Coldspring Lane							
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. ADDRESS		Williams					
Monralez				Charlton		Gwendolyn		Sonja Brown 2700 Cyburn Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Multiple Stab Wounds of Chest 9660 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
										YES XX NO					
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		? P.M. 9 11 1983		subject was stabbed											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
		river bank		Frostburg College Campus, Frostburg, Allegany											
22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide XX, Undetermined manner <input type="checkbox"/> .										Co., Md.					
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant								DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT)		M.D. MEDICAL EXAMINER								9-14-83					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9/17/83		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore,		COUNTY		STATE Md.					
24. FUNERAL DIRECTOR F/H Wm C March Inc.		NAME ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE John J. Conroy									

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

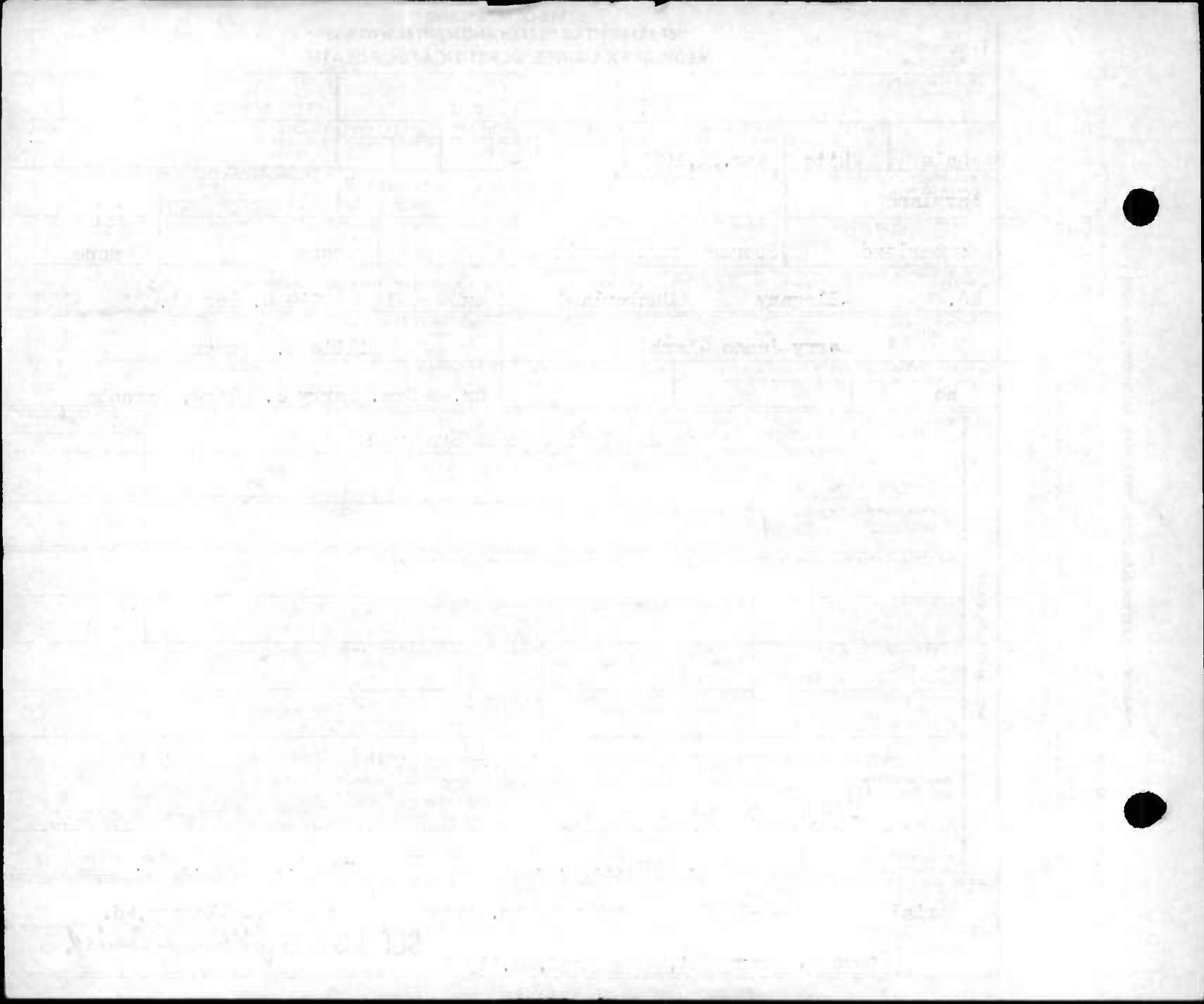
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22872		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
LILIA B. CHRISTMAN						September 28, 1983						10:58 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		MONTH DAY YEAR June 20, 1895			88			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
West Virginia		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Memorial Hospital		Housewife			Own Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Allegany		Cumberland						439 Forester Ave. 21502				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
		Taylor		Shroud	Alice					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			21502				
No		213-48-6743		James A. Christman, Cumberland, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>Congestive Heart Failure</i>														
5850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) <i>Chronic Renal Failure</i>														
{ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pleural Effusions</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				8/23 83			8/29/ 83							
22b. SIGNATURE <i>Richard Schindler</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9-29-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard E. Schindler		22e. ADDRESS 69 Greene Street Cumberland, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 1, 83		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Mem. Park			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME William G. Kight, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR OCT 3 1983		25b. REGISTRAR'S SIGNATURE <i>John G. Cawley</i>										

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22873	
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST Jimmy	MIDDLE Earl	LAST Clark		2a. DATE KNOWN OF ESTI- DEATH MATED	□ MONTH 9 M DAY 5 YEAR 83 2b. HOUR 19 M 12:30 A M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8c. DATE PRONOUNCED DEAD	
Male		White		Apr. 21, 1983		4				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		10. CITY OR TOWN OF DEATH Cumberland	
Md.		USA				<input checked="" type="checkbox"/>		<input type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 224 N. Lee St. 21502		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		12b. KIND OF BUSINESS OR INDUSTRY none	
Larry James Clark						Millie D. Renner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT Mr. & Mrs. Larry J. Clark, Parents		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21g. LOCATION STREET						STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 9/6/83					
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-1983		23c. NAME OF CEMETERY OR CREMATORIAL Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN La Vale, Allegany, Md.					
24. FUNERAL DIRECTOR NAME James F. Scarpelli		ADDRESS Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR SEP 13 1983		REGISTRATION SIGNATURE <i>John J. Connel</i>					
20M 4/4B2 BP		20M 4/4B2 BP									
DHMH - 17 (VR A15 ME (5))											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 22874			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
			Lon D. Cook			Sept. 4, 1983									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH DAY YEAR		78			MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
West Virginia		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Cresaptown		Amcelle Street										Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													13b. STREET ADDRESS		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Amcelle Street						
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST					
Isaac N. Cook					Etta F. Clayton										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		220-10-7398		Mr. Raymond D. Cook, Cumberland, Son											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Lung.</u>															
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Severe generalized arteriosclerosis.</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-24-83 to Sept 4, 1983, that (I) (we) last saw the deceased alive on 8-24-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Robert J. Barker, Jr.</u> DEGREE MD															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED							
ROBUSTIANO J. BARKER		MEMORIAL HOSP. CUMS, MD.						- 9-5-83							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			COUNTY						
Burial		9-7-1983		Zion Memorial Park		Cumberland, Allegany, Md.			STATE						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.					SEP 13 1983			<u>John J. Canale</u>							



SCARPELLI FUNERAL HOME
108 VIRGINIA AVENUE
CUMBERLAND, MD 21502

83 22875

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
				AMEDEO	NMI	D'ASCENZO (DASCENZO)	SEPTEMBER 21, 1983				11:10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		March 16, 1906			77 YRS.				IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Pennsylvania		USA					ALLEGANY COUNTY,				12b. KIND OF BUSINESS OR INDUSTRY Shoemaker			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Cumberland		SACRED HEART HOSPITAL		Retired				206 Lincoln Ave. 99999						
13a. STATE Pennsylvania		13b. COUNTY		13c. CITY OR TOWN Meyersdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
								206 Lincoln Ave. 99999						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				17. INFORMANT ADDRESS	
					Rosaliva								Daughter Mrs. Alcea M. Giatras, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma of Stomach</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approximately 15 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>9/3</i>		21f. LOCATION STREET <i>9/3</i>		CITY OR TOWN <i>9/21</i>		COUNTY <i>1983</i>		STATE <i>9/21 1983</i>				
22a. I certify that (I) (the physician) attended the deceased from <i>9/21</i> , 1983, to <i>9/21</i> , 1983, that (I) (we) last saw the deceased alive on <i>9/21</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Andrew Stasko M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <i>9-22-83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS										
ANDREW STASKO, M.D.		924 SETON DRIVE, CUMBERLAND, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-1983		23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.		23d. LOCATION CITY OR TOWN Cumberland, Allegany Md.		23e. COUNTY Allegany		23f. STATE Md.				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 29 1983		25b. REGISTRAR'S SIGNATURE <i>Renee L. Carroll</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be held until final burial or removal, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be advised and called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22876
1 - STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
CHARLES EDWARD DAVIS					Sept. 2, 1983					4:00 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		White		Month Day Year Jan. 6, 1898		85			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN	
Iowa		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Little Orleans		Rt. #1 Box 89		Laborer			State Roads			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Little Orleans		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 69 21766		
14. FATHER'S NAME FIRST James		MIDDLE Elmer		LAST Davis		15. MOTHER'S MAIDEN NAME FIRST Marian		MIDDLE LAST Overholser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
No		213-18-2520		Gladys Davis		same as 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
3310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Due to, or as a consequence of } (c) Due to, or as a consequence of										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 11-22-1958 to 9-2-1983, that (I) <input type="checkbox"/> last saw the deceased alive on 4-8-83, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE FB Thomas III MD		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 2, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Two Tonoloway Hancock, Md. 21750				Frank B. Thomas, III, M.D., P.A.				
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 9/6/1983		23c. NAME OF CEMETERY OR CREMATORIAL Piney Plains Methodist		23d. LOCATION CITY OR TOWN Little Orleans		COUNTY Allegany		STATE Md.
24. FUNERAL DIRECTOR NAME Richard J. Lane Hancock MD		ADDRESS				25. DATE REC'D. BY REGISTRAR SEP 13 1983		25. REGISTRAR'S SIGNATURE J. Langford		

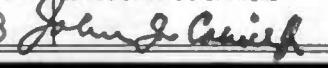
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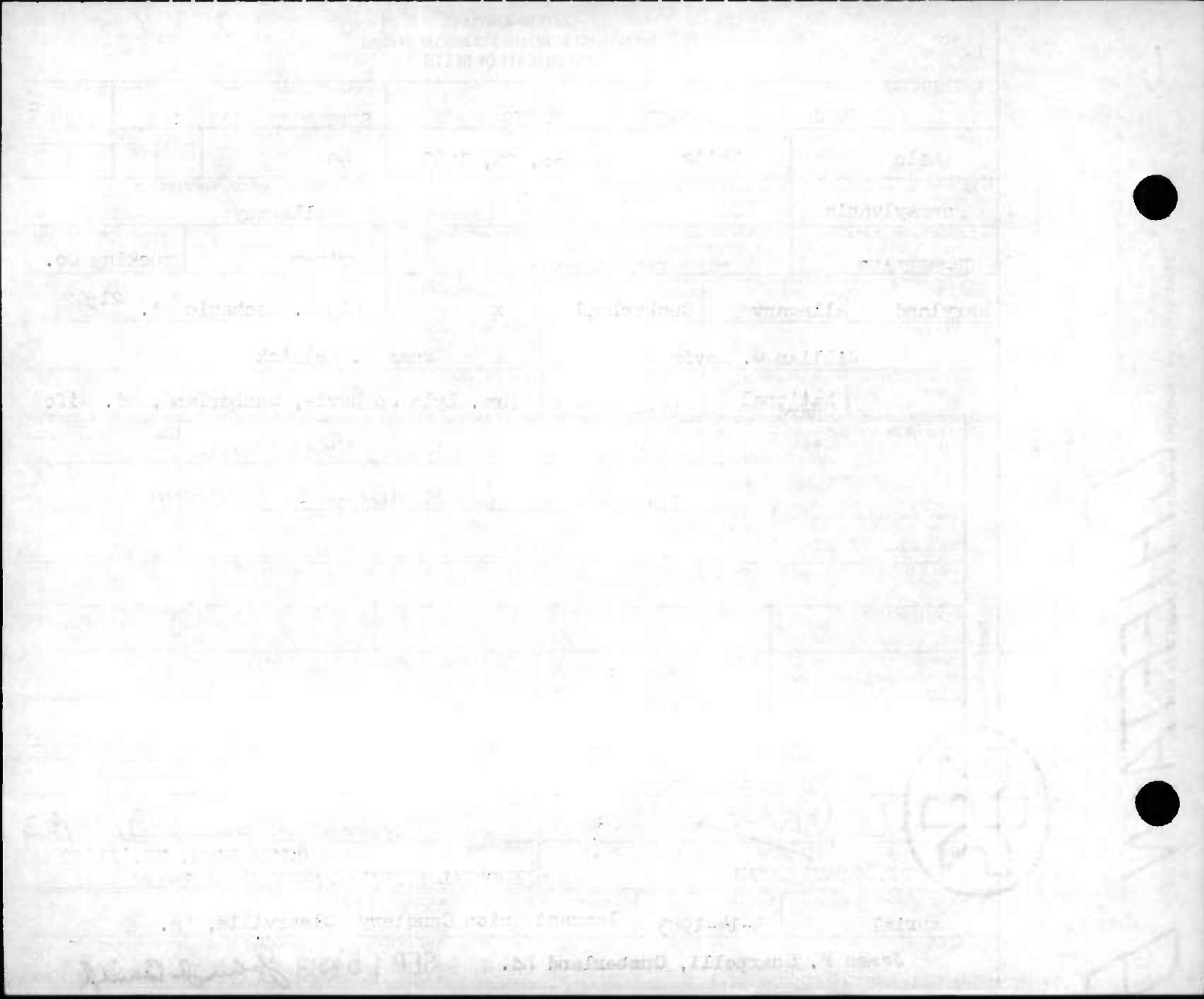
Second edition.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22871			
1 - FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
DELL		DANIEL						DAVIS			SEPTEMBER	11	1983		3:20 a.m.
3. SEX Male		4. RACE White			5. DATE OF BIRTH Month Day Year Dec. 24, 1933			6. AGE (IN YEARS LAST BIRTHDAY) 49			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 613 N. Mechanic St. 21502							
14. FATHER'S NAME FIRST William C. Davis		MIDDLE LAST			15. MOTHER'S MAIDEN NAME Emma M. Helmick										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) National Guard		16b. SOCIAL SECURITY NO. 171-28-8001			17. INFORMANT Mrs. Lyla Jo Davis, Cumberland, Md. Wife			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLY CEREBRAL BLEEDING 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF CHRONIC LYMPHOCYTIC LEUKEMIA (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/12/83			
22b. SIGNATURE 					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. QAMAR ZAMAN		22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING						CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 9-14-1983			23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Union Cemetery			23d. LOCATION CITY OR TOWN Clearville, Pa.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland Md.								25a. DATE REC'D. BY REGISTRAR SEP 15 1983		REGISTRAR'S SIGNATURE 					



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 22878						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	2b. HOUR			
RAYMOND WILLIAM DAWSON					09 04 83		3:17PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
Male		White		01 31 19		72 YRS					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Brakeman		12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. STATE WEST VIRGINIA		13b. COUNTY MINERAL		13c. CITY OR TOWN WILEY FORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Highland Ave. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST		Norvel Dawson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		Mary Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-3607		17. INFORMANT		ADDRESS Mrs. Catherine Dawson, Wiley Ford, W.Va. Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4140		Cardiac Arrest		DUE TO, OR AS A CONSEQUENCE OF (b) Possible asphyx		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I AS CVSD → COPD											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. J. G. Stansberry, M. D.		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/14/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Memorial Hospital, Cumberland, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-7-1983		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Nebo Cemetery		23d. LOCATION CITY OR TOWN Near Berkeley Springs, W. Va. COUNTY STATE					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25. REG'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 13 1983 John L. Comer									
DHMH - 16 50M 1/81 (VRA 15, 4)											

DATE NO. 20

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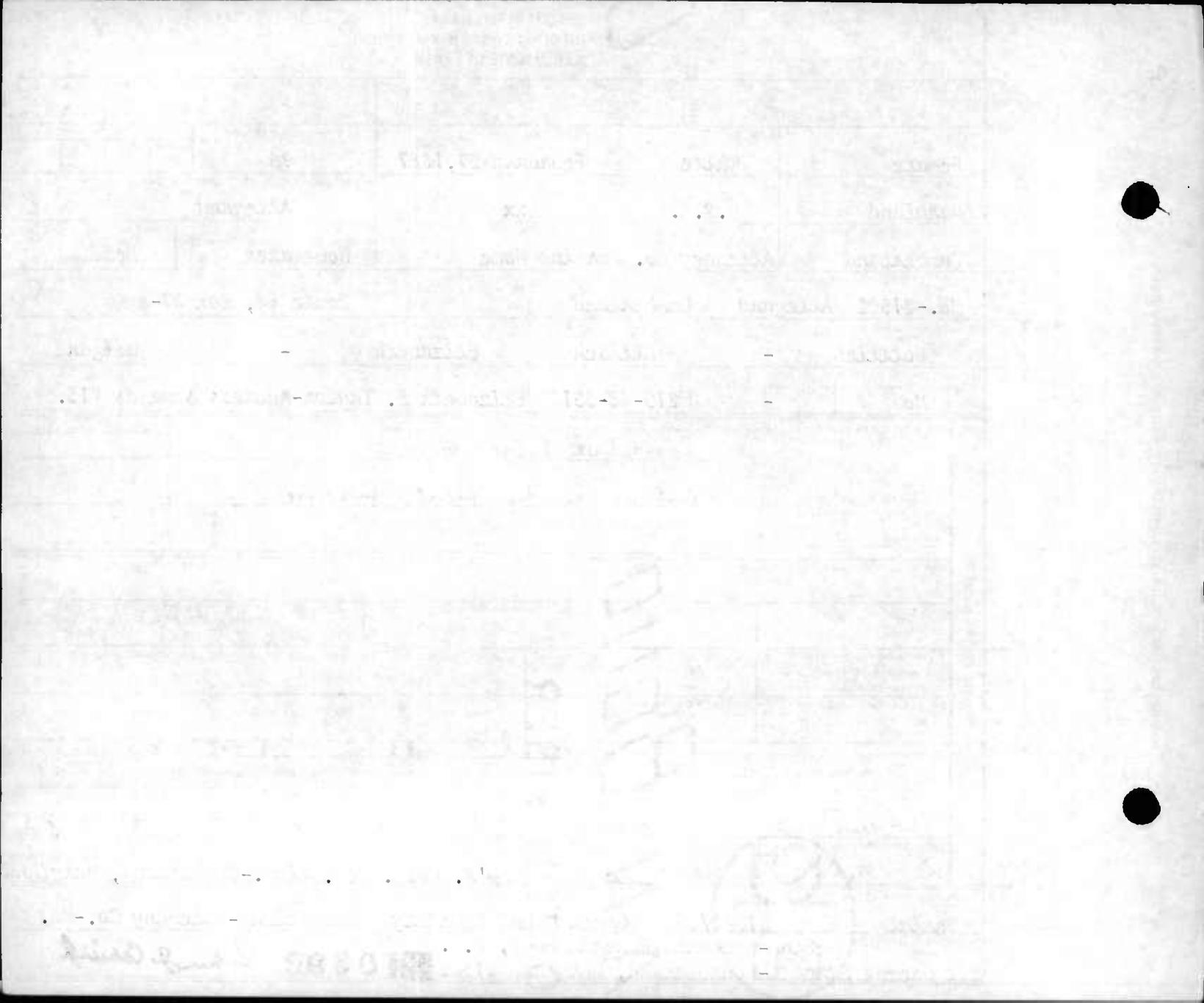
INDEXED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled fully, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 will remain attached within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	22879	
										REG. NO.		
1 - FOR STATE REGISTRAR	1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
	Margaret A. Dean				9-28-83				9:10 PM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	February 27, 1887			96	YRS.	MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD				
Maryland	U.S.A.				Allegany							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland	Allegany Co. Nursing Home					Homemaker			Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.-21502	Allegany	Cumberland				Route #4, Box 87-a 21502						
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			Weigand		
Gottlieb	-	Klitsch	Elizabeth			-						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS									
No	215-48-3510	Elizabeth S. Taylor-Address same as #13.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4140 Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 1983 to 9-28-1983, that (I) (we) last saw the deceased alive on 9-28-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robustiano J. Barrera, Jr. MD										22c. DATE SIGNED 9-28-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
ROBUSTIANO J. BARRERA, JR.		Mem'l. Hosp. Med. Bldg.-Cumberland, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/1/83		23c. NAME OF CEMETERY OR CREMATORIUM Green Mount Cemetery		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A. 202 Greene Street - Cumberland, Maryland 21502												
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John J. Caneff												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DURST FUNERAL HOME 57 FROST AVENUE FROSTBURG, MD 21532			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 3 22880		
						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
NELLIE	CATHERINE	EICHORN		SEPT. 17, 1983				10:35AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 3 DAY 9 YEAR 37	6. AGE (IN YEARS LAST BIRTHDAY) 46	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 336 Allegany St.				
14. FATHER'S NAME FIRST John	MIDDLE R.	LAST Watson	15. MOTHER'S MAIDEN NAME Nellie	16. SOCIAL SECURITY NO. 220-40-1128				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2396	DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Brain Tumor	17. INFORMANT William Eichorn ADDRESS 336 Allegany St.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.								
{ DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Brain Tumor								
{ DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE K. Ashker		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 9-24-83		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KEFFER ASHKER, M.D.		22f. ADDRESS MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/83		23c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery		23d. LOCATION CITY OR TOWN Eckhart Allegany Md.		
24. FUNERAL DIRECTOR NAME Durst Funeral Home		25a. ADDRESS 57 Frost Ave.		25b. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE Sep 28 1983 John J. Durst				

Condite, Inc., and its wholly

subsidiaries, and its officers, directors, employees, agents, contractors, and consultants.

2. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

3. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

4. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

5. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

6. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

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8. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

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13. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

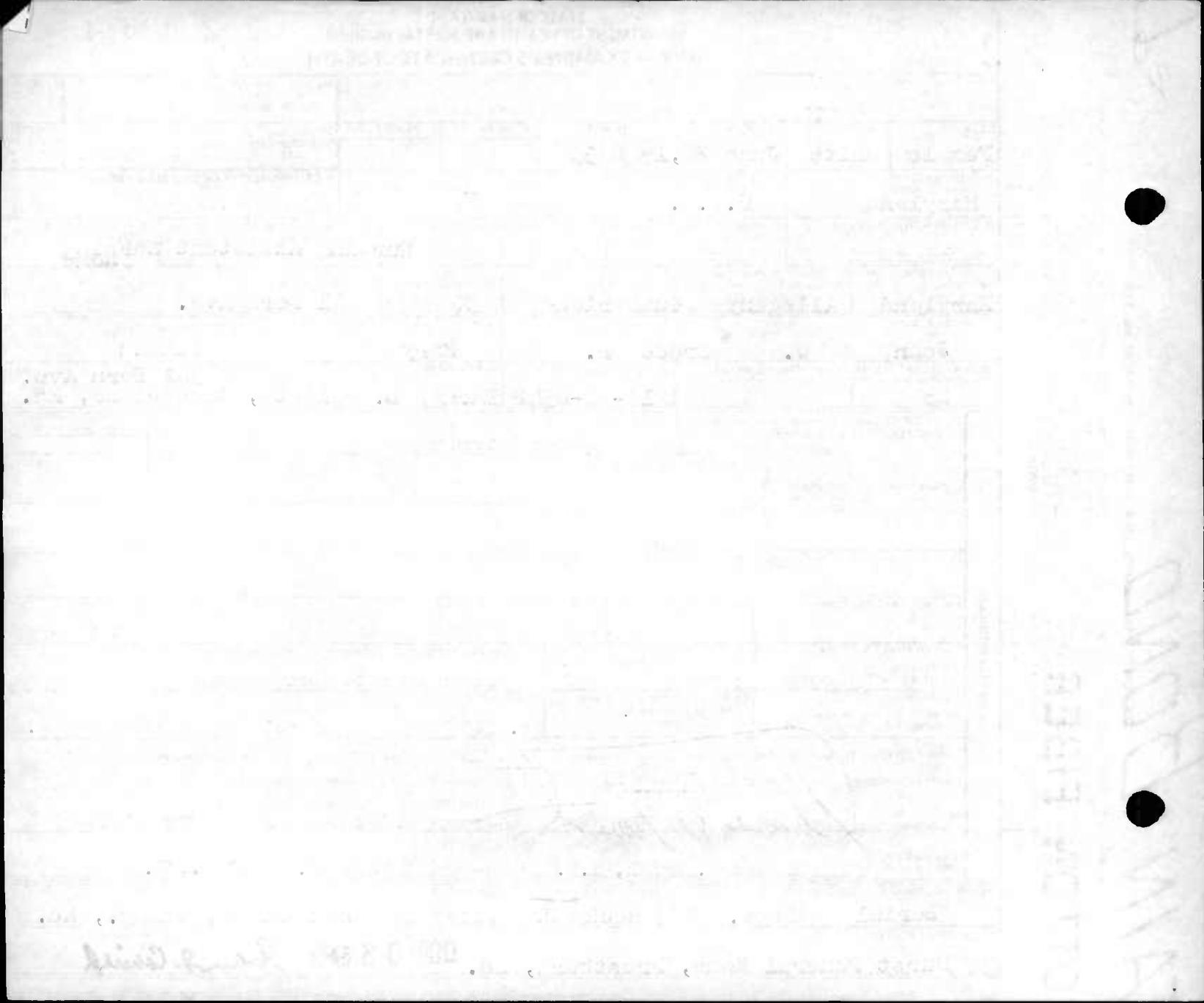
14. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

15. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

16. The Company shall not, directly or indirectly, make any statement, written or oral, which would be misleading if made in light of the facts known to the Company at the time of such statement.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22881
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
Ellen Lee Elliott						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	26	1983	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR LAST BIRTHDAY YRS.			6. AGE IN YEARS LAST BIRTHDAY YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD
Female	White	June 28, 1948			35							9 26 1983
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County,			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Assistant			12b. KIND OF BUSINESS OR INDUSTRY Nursing Home			
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 341 Dorn Ave. 21502				
14. FATHER'S NAME John W. Brode Sr.			15. MOTHER'S MAIDEN NAME Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-52-0542			17. INFORMANT Thomas L. Elliott, Cumberland, Md.			ADDRESS 341 Dorn Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio cerebral trauma 8/60 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1:45 P.M.			21b. TIME OF INJURY HOUR XIX MONTH 9 DAY 26 YEAR 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Driver of auto lost control						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 546			CITY OR TOWN Finzel	COUNTY Garrett	STATE Md.	
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion			
ACTUAL SIGNATURE <i>Thomas D. Smith</i>												
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D.			ADDRESS 111 Penn St., Balto., MD.			DATE SIGNED 9/27/83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 30 '83			23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap Veterans			23d. LOCATION CITY OR TOWN Cumberland, Alleg., Md.			
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCTO 3 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is the duty of the hospital or attending physician to sign the certificate.

ZIEGLER FUNERAL HOME
HYNDMAN, PA.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22882

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ROY EDGAR EMERICK						SEPTEMBER 25, 1983				11:20AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Caus		May 5, 1924			59 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Md.		USA					ALLEGANY COUNTY, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		SACRED HEART HOSPITAL		Foreman			Town Maint.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Pa.		Bedford		Hyndman				Box 342 15545		99999	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS			
Russell E. Emerick						Florence E. Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.											
16c. IF YES, GIVE WAR OR DATES) 17. INFORMANT											
yes WWII 220 16 7151 Martha S. Emerick, Box 342, Hyndman, Pa.											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary neberkect x effusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <u>Ca of the lung with mised</u> DUE TO, OR AS A CONSEQUENCE OF Underlying cause (b). <u>Selvus gas so UTI</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>83</u> , to <u>9-25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		MEHANNA, JOHN M.D.			909-B SETON DR. CUMBERLAND, MD. 21502			9-26-83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		
Burial		9/27/83		Hyndman Cemetery			Hyndman, Bedford, Pa.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Harvey H. Zeigler, Hyndman, Pa.					SEP 29 1983			Dee & Cawie			

602:11 3891 .20 CERTIFICATE

11 EDITION

PAGE 31 OF 32

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

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BY THE GOVERNMENT OF CANADA

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22883		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
Edward Gordon Farrell						<input checked="" type="checkbox"/>			9	10	1983	1015am		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	6 11 1916	67					<input checked="" type="checkbox"/>			9	10	1983	1015am
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD		USA					Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland		Sacred Heart Hospital			Military operator			A.B.L.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		MD. 213 New Row Street 21545					
Maryland		Allegany		Mt Savage										
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST					
		John	M	Farrell			Susan	E	Shaffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II			17 INFORMANT			ADDRESS					
			217-10-5167			Esther Farrell			21545 213 New Row St. Mt. Savage, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive Bleeding												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1991 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.														
(b) <u>cutaneous fistula in right neck</u>														
(c) <u>metastatic squamous Carcinoma</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?								
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		Francisco Reyes			M.D.		TITLE (SPECIFY)		DATE SIGNED 9-10-83					
EXAMINER'S NAME (TYPE OR PRINT)		Francisco Reyes			ADDRESS		Deputy							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE		
Burial			9-13-83			St. Patrick's Cath. Cemet.			Mt. Savage Allegany			MD		
24 FUNERAL DIRECTOR NAME			ADDRESS			21502			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Silcox-Merritt F.H.			404 Decatur St. Cumb., MD						SEP 14 1983			John J. Davis		

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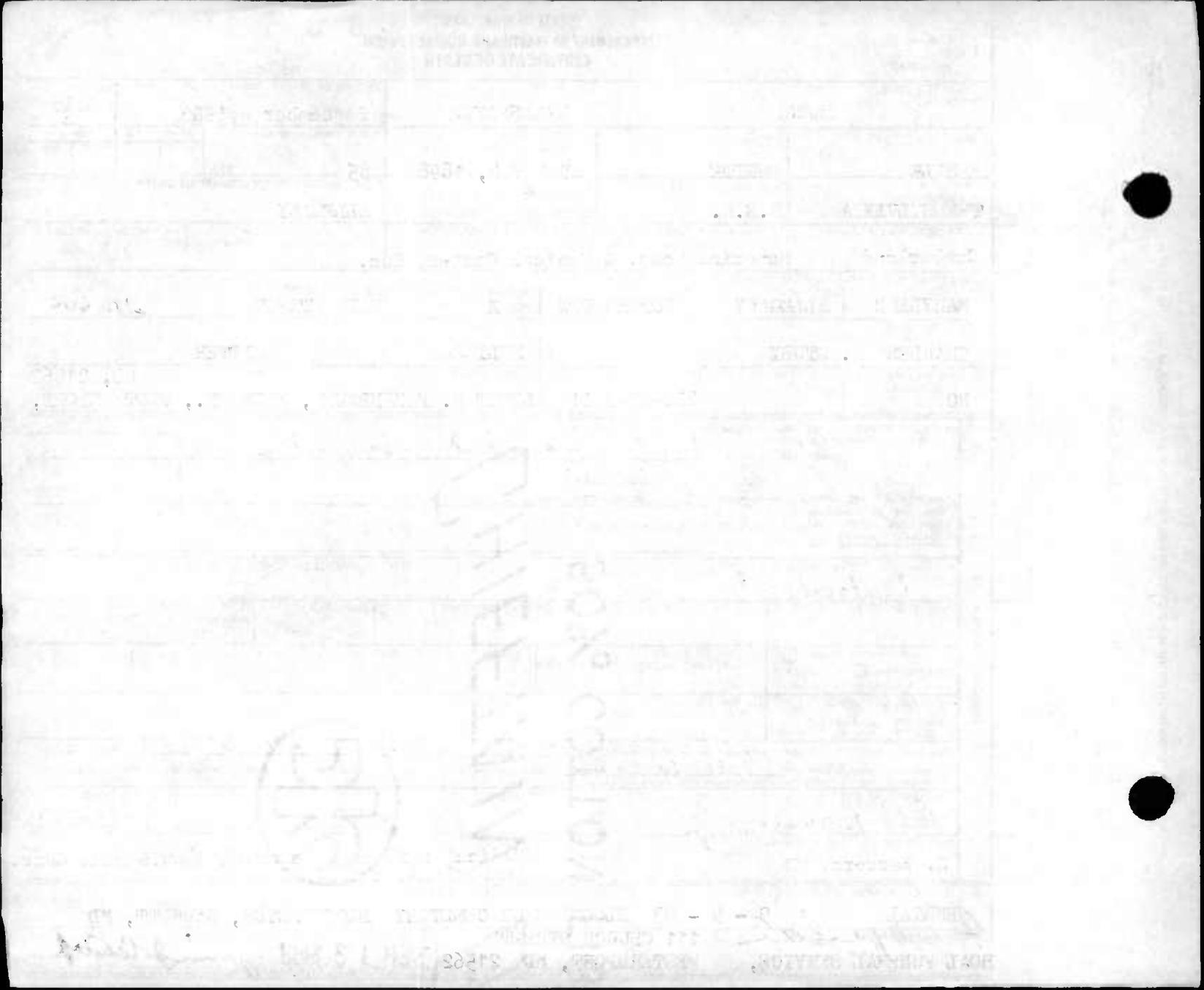
April 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 2 8 8 4				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
IRENE					FAZENBAKER	September 6, 1983						8:15 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE			AUGUST 4, 1898			85			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
PENNSYLVANIA			U.S.A.						ALLEGANY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland			Memorial Hosp. & Medical Center, Inc.													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21562				
MARYLAND		ALLEGANY		WESTERNPORT					MAIN STREET							
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS							
FIRST CHARLES			MIDDLE E. STUBY			FIRST MELISSA			LAST MITTER			MD, 21562				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> <u>Acute myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			216-22-5611			ALBERT S. FAZENBAKER, MAIN ST., WESTERNPORT,										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
<u>Cerebrovascular Accident</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9-6-83</u> to <u>9-6-83</u> , that (I) (we) lost saw the deceased alive on <u>9-6-83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>R. Barrera, Jr.</u>			22c. DEGREE			22d. ADDRESS Medical Building, Memorial Hosp. & Med. Ctr. Cumberland, MD 21502			22e. DATE SIGNED <u>9-8-83</u>							
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE <u>9-9-83</u>			23c. NAME OF CEMETERY OR CREMATORIAL BLOOMINGTON CEMETERY			23d. LOCATION CITY OR TOWN BLOOMINGTON, GARRETT, MD							
24a. FUNERAL DIRECTOR NAME BOAL FUNERAL SERVICE,			24b. ADDRESS 111 CHURCH STREET WESTERNPORT, MD 21562			25a. DATE REC'D. BY REGISTRAR SEP 13 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conigli</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Scarpelli Funeral Home 1 - FOR STATE REGISTRAR 108 Va. Avenue Cumberland, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 2 8 8 5																	
1. DECEASED NAME (TYPE OR PRINT) (Eileen) Ellen NMI Feddis				2a. DATE OF DEATH September 20, 1983				REG. NO.																	
3. SEX Female				4. RACE White				5. DATE OF BIRTH April 24, 1924				6. AGE (IN YEARS LAST BIRTHDAY) 59													
7a. BIRTHPLACE COUNTRY Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County				10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse				12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 718 Washington Street																	
14. FATHER'S NAME Michael Dolan								15. MOTHER'S MAIDEN NAME Delia																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 122 30 9864		17. INFORMANT Dr. Robin Feddis				ADDRESS Cumberland, MD																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of colon- hepatic flexure</i> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 month									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Heredental obstruction due to metastases</i>																									
19a. DATE OF OPERATION April 1 Sept 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED A-colon - obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE													
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 30 1983</i> to <i>Sept 20 1983</i> , that (I) (we) last saw the deceased alive on <i>Sept 19 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE <i>Thomas J. Lewis</i>																22c. DEGREE									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Lewis, M.D.																ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-22-83				23c. NAME OF CEMETERY OR CREMATORIAL St. Mary Cemetery				23d. LOCATION CITY OR TOWN Cumberland				COUNTY Allegany									
24. FUNERAL DIRECTOR NAME <i>James J. Scarpelli</i>				ADDRESS Cumberland, MD				25. DATE REC'D BY REGISTRAR SEP 26 1983				25. REGISTRAR'S SIGNATURE <i>John J. Scarpelli</i>													

2025 RELEASE UNDER E.O. 14176

• Get what you want

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

43 22886

1 - FOR
STATE
REGISTRAR

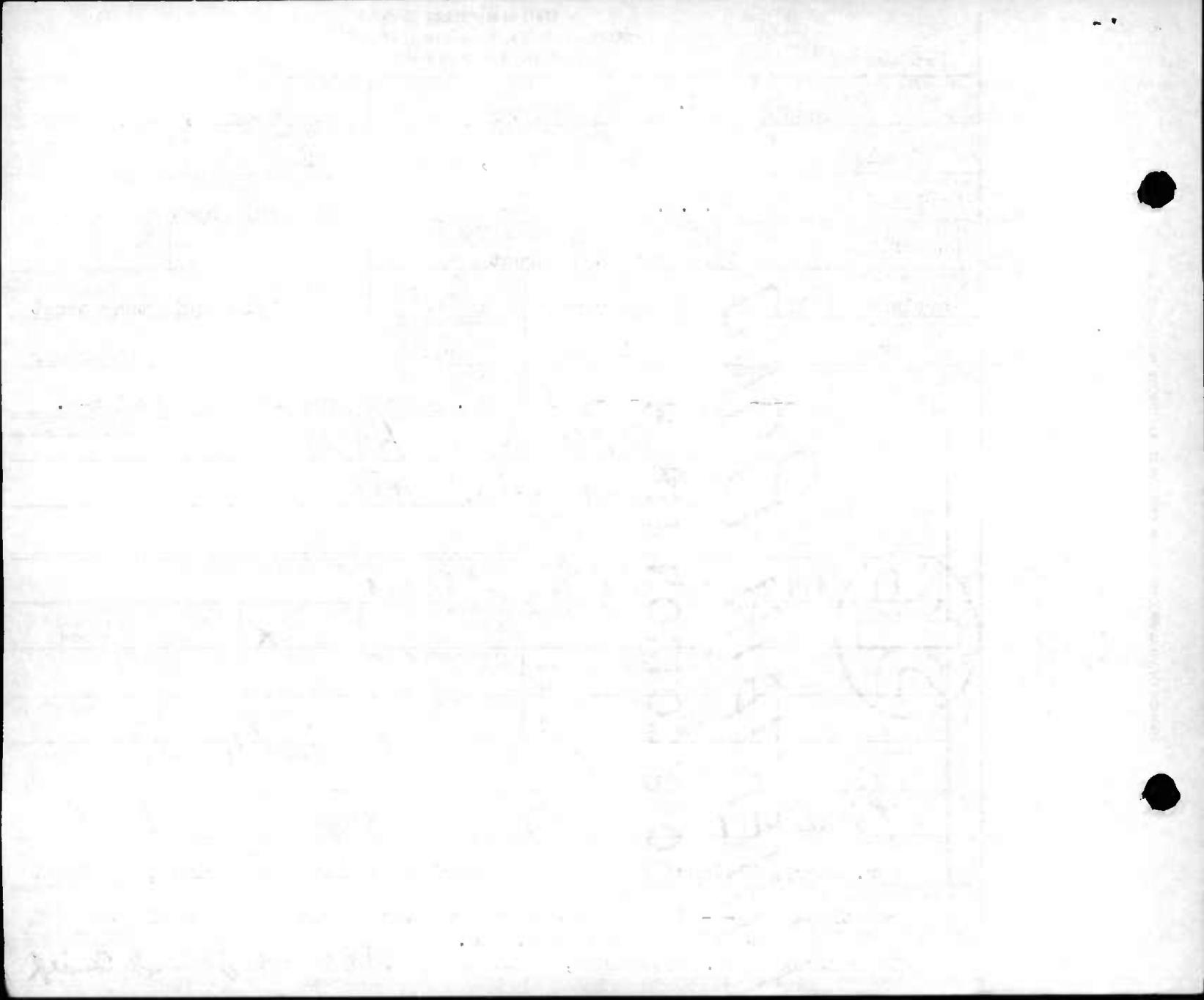
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Bessie	S.	Fichter	September	1,	1983		11:55P	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White	May 9, 1891			92		IF UNDER 24 HRS HOURS MIN			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		U.S.A.					Allegany County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		731 Washington Street									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21502			
Maryland		Allegany	Cumberland			731 Washington Street					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				Landhramer			
Aaron			Sindler	Cecilia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
No		270-16-2883			Mrs. Roseann Bernstein		same as 13a-e.				
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, and up to three causes for Part 2). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Major CVAs, CAD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, IF NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Hypertension, diabetes, 200 mg triglycerides</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>July 13, 1983</i>			21f. LOCATION STREET <i>81</i> CITY OR TOWN <i>81</i> COUNTY <i>81</i> STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 9, 1983</i> , to <i>July 1, 1983</i> , that (I) (we) lost sow the deceased alive on <i>Aug 9, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Terry Williams</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>9/2/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Terry Williams</i>		22e. ADDRESS <i>Memorial Hospital Cumberland, MD 21502</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-2-83		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg		COUNTY Washington		STATE MD	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc. ADDRESS 230 Baltimore Ave. Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR <i>SEP 6 - 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



K2 X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If check (2) is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

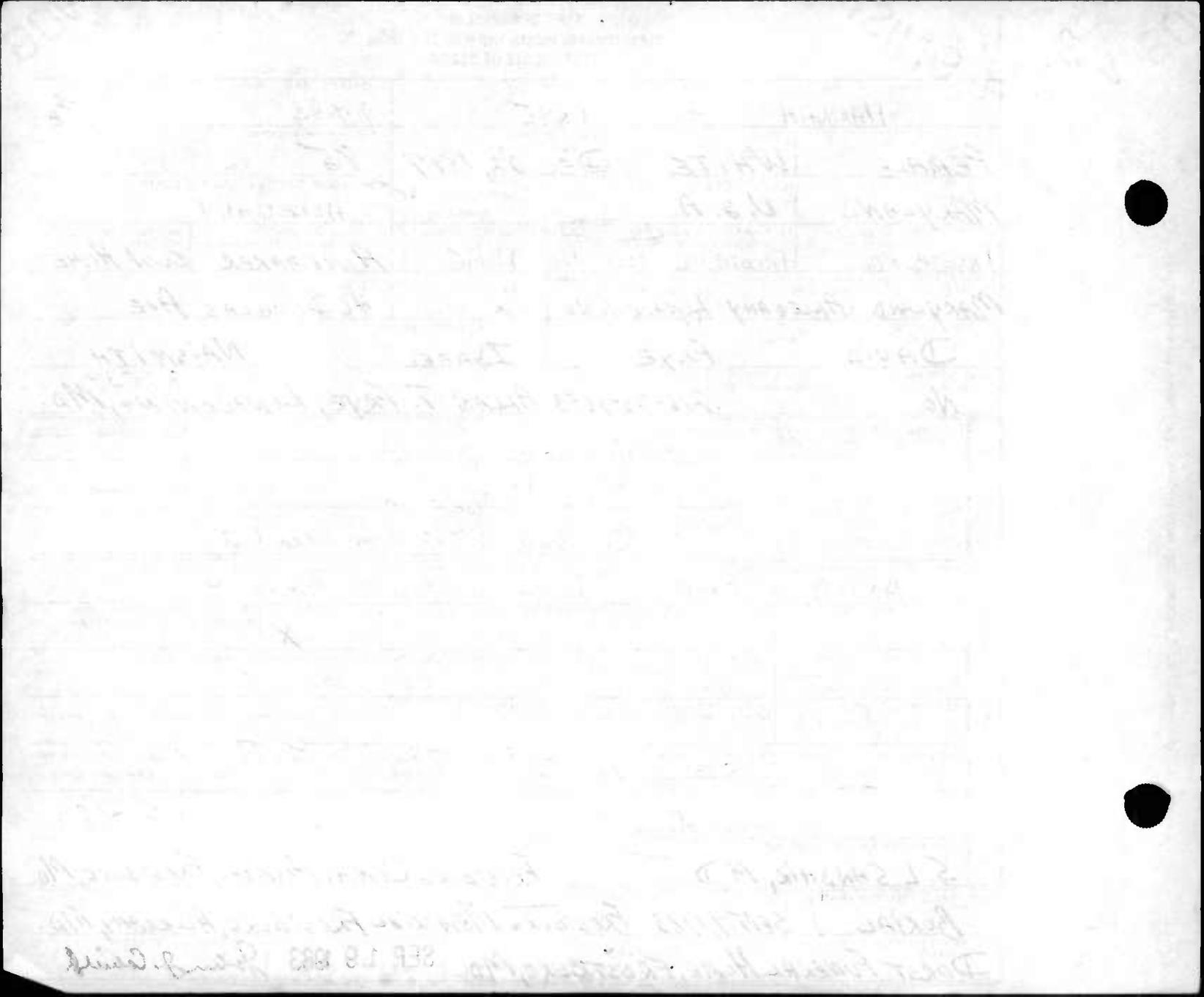
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CHARLES GEORGE FISHER SR.				September 18, 1983				4:10 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 4, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN机构, FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Med. Center Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Railroad		MD.	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 516 Marietta St. 21502	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	
Richard L. Fisher						Augusta Weber		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) War II		16c. SOCIAL SECURITY NO. 217-18-4469		17. INFORMANT Mrs. Virginia Fisher, Cumberland, Md. Wife		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent oat cell carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>D. Jones</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Q. Zaman		22e. ADDRESS Medical Building, Memorial Hosp. & Med/ Ctr. Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 9-21-1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME James F. Scarpelli		24b. DATE REC'D. BY REGISTRAR SEP 22 1983		24c. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Issue 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an examination made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 35 22888			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 9-7-83							2b HOUR 10 AM			
1. DECEASED NAME (TYPE OR PRINT) HANNAH T. FRYE			5 DATE OF BIRTH MONTH DAY YEAR DEC-22, 1897			6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
3. SEX FEMALE		4 RACE WHITE		7 DATE OF DEATH MONTH DAY YEAR DEC-22, 1897			8 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			10b HOUR 10 AM			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ALEGANY MD.						
10 CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FROSTBURG VILL. Nsg. HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER			12b KIND OF BUSINESS OR INDUSTRY OWN HOME						
13a STATE MARYLAND		13b COUNTY ALEGANY		13c CITY OR TOWN KONAONING			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 46 DOUGLAS AVE. 21539			
14 FATHER'S NAME DAVID		15 MOTHER'S MAIDEN NAME FRYE ISABEL NAISMITH		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 216-38-1653			17 INFORMANT ALLAN T. FRYE, KONAONING, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360		19a DATE OF OPERATION ASHD		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		21c CONDITION FOR WHICH OPERATION WAS PERFORMED CHF. Organ Enzyme Studies		21d HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 831 1983			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
21g INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21h SIGNATURE S. L. SANDHIR, M.D.		22a ADDRESS Frostburg Comm. Hospital, Frostburg, Md.			21i LOCATION CITY OR TOWN FROSTBURG, ALLEGANY, MD.			22b DATE SIGNED 9/7/83			
22b SIGNATURE S. L. SANDHIR, M.D.		22c ADDRESS Frostburg Comm. Hospital, Frostburg, Md.		23a BURIAL, CREMATION, REMOVAL SPECIES Burial			23b DATE SEPT. 9, 1983			23c NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL			
24 FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.		25a DATE REC'D. BY REGISTRAR SEP 19 1983		25b REGISTRAR'S SIGNATURE John J. Conroy									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page A may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 22889								
1 - FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR								
ELIZABETH E. GEARE					SEPTEMBER 12, 1983								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		21. HOUR 6:10 P.M.							
Female		White		Dec. 1, 1889		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		93 YRS.					
Maryland		U.S.A.				Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, ONE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND		MEMORIAL HOSPITAL			Housewife		Home						
13a. STATE Md. - 21502		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 321 Fayette Street 21502					
14. FATHER'S NAME FIRST John		MIDDLE Turner		LAST Edwards		15. MOTHER'S MAIDEN NAME FIRST Effie		LAST Jameson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS Rt. #4, Box #141 Deer Park, Md.							
No		--		220-44-2785 John E. Geare-									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>5990</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Indwelling Foley catheter, old age, Quadriplegia from CVAs</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>81</u> , to <u>Sept. 12</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>September 12, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Dr. N. Ranjithan</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/13/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan						22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/15/83		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Burial Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-Md.		25a. DATE REC'D. BY REGISTRAR SEP 16 1983				25b. REGISTRAR'S SIGNATURE <u>George Upchurch</u>	
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A. ADDRESS 202 Greene Street - Cumberland, Md. 21502													



8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR CUMBERLAND MD. 21502			SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			CERTIFICATE OF DEATH			REG. NO. 8522890			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
ELWOOD NMI HARDEN						SEPTEMBER 11, 1983						2:00A			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White		MONTH DAY YEAR NOV. 30 1918		64			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD			USA				ALLEGANY COUNTY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland			SACRED HEART HOSPITAL						machinist helper Chessie						
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 227 Hambird St. 21545						
14. FATHER'S NAME FIRST Charles			MIDDLE		LAST Harden		15. MOTHER'S MAIDEN NAME Mabel		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II		16c. ADDRESS 705-10-8429		17. INFORMANT Ginger Paul Rfd 3 307 Marion Court Rawlings,		MD 21557						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u>												
1629			DUE TO, OR AS A CONSEQUENCE OF (b) <u>wide spread metastatic sat</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) <u>all ca of the lung</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-29</u> , 19 <u>83</u> , to <u>9-10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John Mehanna M.D.</u>			DEGREE						22c. DATE SIGNED <u>9-11-83</u>						
THE PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS 912 SETON DRIVE CUMBERLAND MD, 21502												
JOHN MEHANNA M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-13-83		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d. LOCATION CITY OR TOWN Cumberland Allegany			COUNTY MD					
Burial															
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H.			ADDRESS 404 Decatur St. Cumb. MD		21502		25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE <u>SEP 14 1983 John J. Canfield</u>					
BP _____															
DHMH - 16 50M 4/82 (VRA 15, 4)															

Experiments on the effect of temperature

ATP2B1 TUGHT QEDAA

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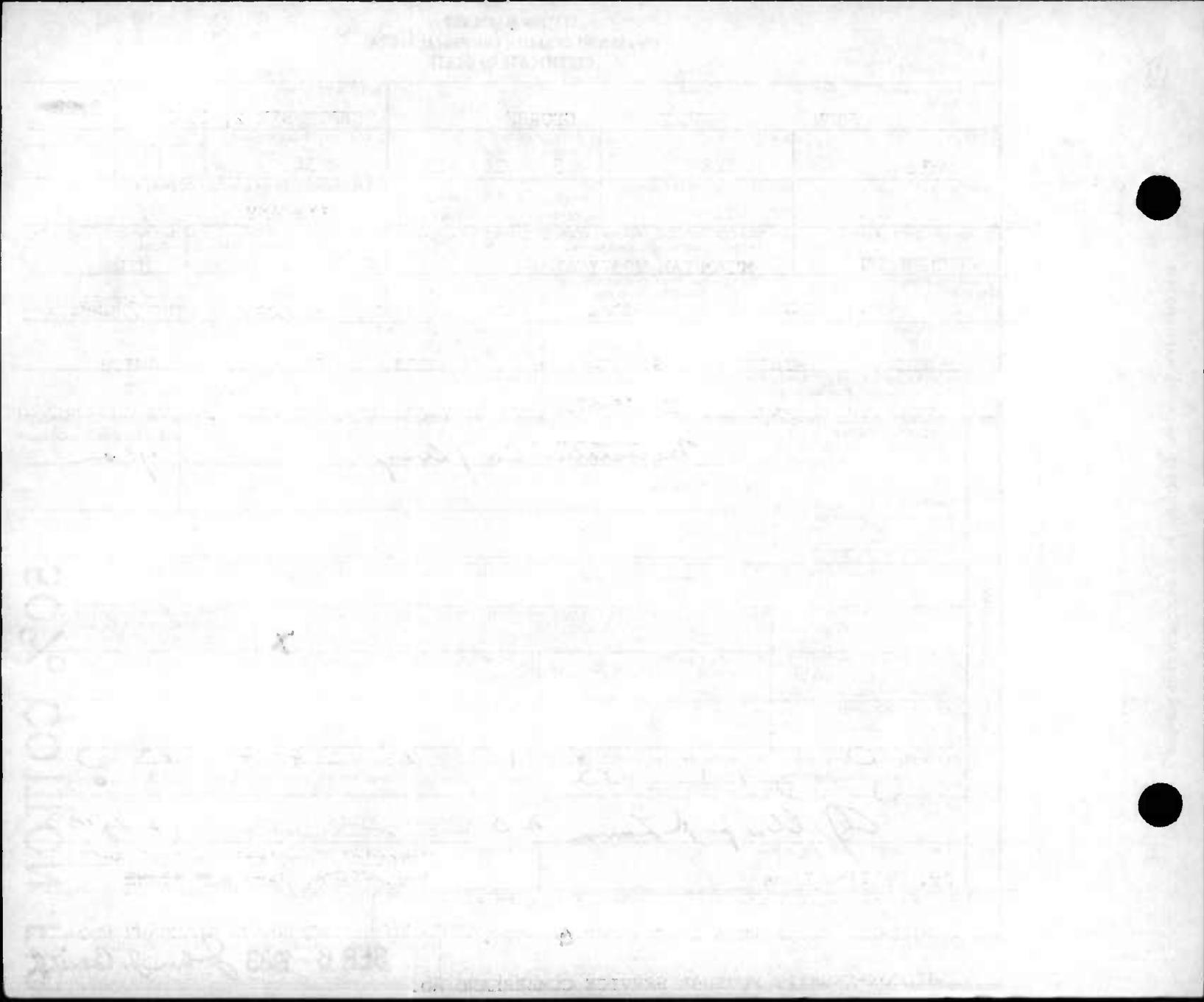
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 83 22891								
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR 8:22 P.M.							
JOHN ROBERT GEORGE				SEPTEMBER 2, 1983													
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH MONTH 5 DAY 26 YEAR 29	6. AGE (IN YEARS LAST BIRTHDAY) 54			IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 8 MIN. 22										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.														
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) QUEEN CITY DAIRY			12b. KIND OF BUSINESS OR INDUSTRY MILK												
13a. STATE MD.	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS RFD2 HILLCREST DRIVE CUMBERLAND MARYLAND 21502													
14. FATHER'S NAME FIRST JOHN MIDDLE WILSON LAST GEORGE	15. MOTHER'S MAIDEN NAME FIRST FLOSSIE MIDDLE BEATRICE LAST SMITH																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. 220-16-6798	17. INFORMANT EMMA ATKINSON RFD2 HILLCREST DRIVE CUMBERLAND MARYLAND 21502															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hysteria - Co / lung</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE										
22a. I certify that (I) (this hospital) attended the deceased from 8-19 , 19 83 , to 9-2 , 19 83 , that (I) (we) last saw the deceased alive on 9-1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Beller & Lamm</i>			22c. DEGREE MD	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 2 Sept 83												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Lamm			22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE SEPT 6 1983	23c. NAME OF CEMETERY OR CREMATORIAL ROCKY GAP VET. CEMETERY	23d. LOCATION CITY OR TOWN CUMBERLAND ALLEGANY MD.	COUNTY		STATE											
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.	ADDRESS	25a. DATE REC'D. BY REGISTRAR'S REGISTRAR'S SIGNATURE SEP. 6 1983 John J. Conroy															
DHMH - 16 50M 4/B2 (VRA 15, 4)																	

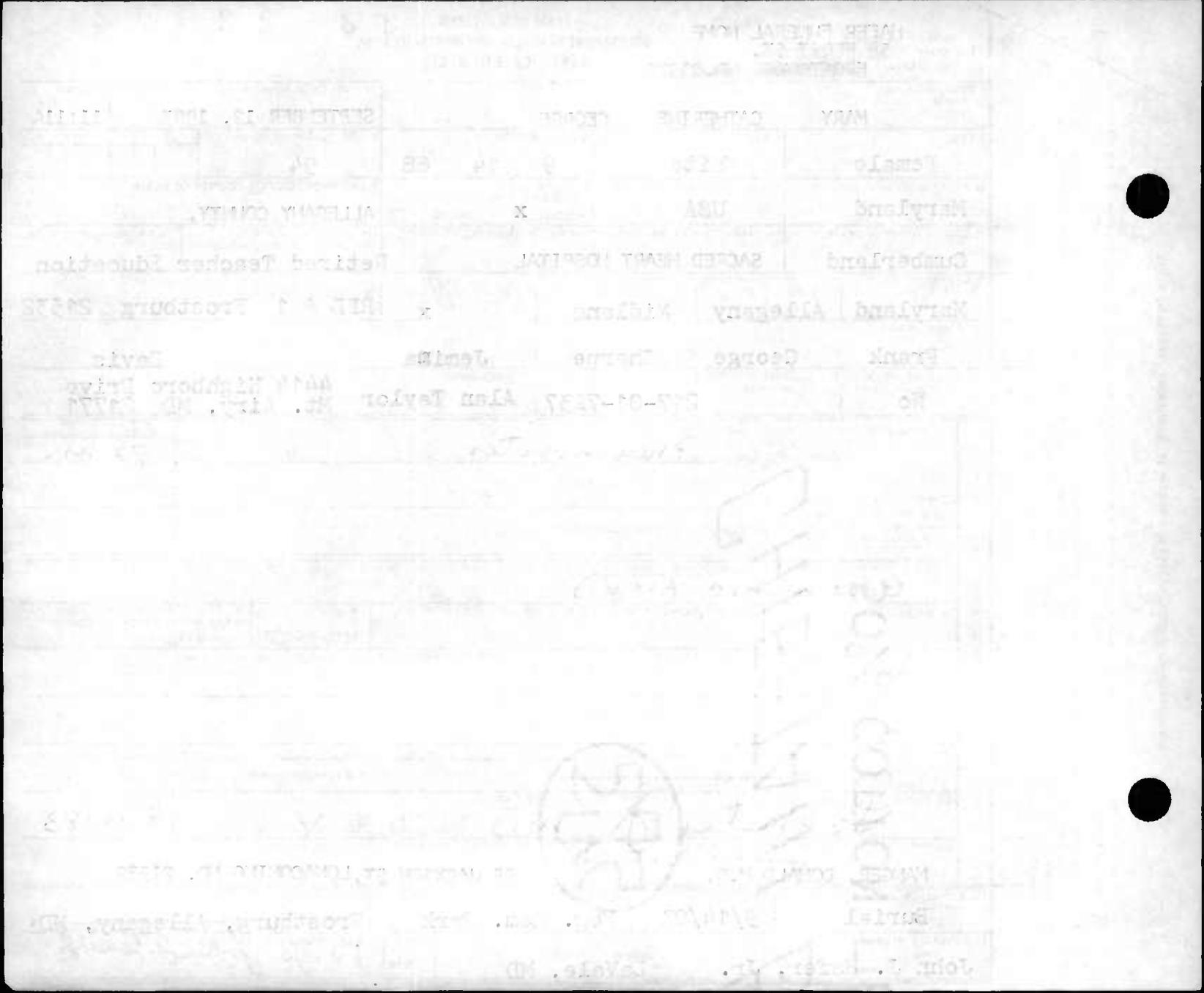


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HAFER FUNERAL HOME 1 - STATE 58 FROST ST. REGISTRAR FROSTBURG, MD. 21532			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 3 22892		
1. DECEASED NAME (TYPE OR PRINT)			REG. NO.					
MARY CATHERINE GEORGE								
2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
SEPTEMBER 12, 1983			11:11 AM					
3. SEX			4. RACE			5. DATE OF BIRTH		
Female			White			MONTH 9 DAY 14 YEAR 88		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS SACRED HEART HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Midland		
14. FATHER'S NAME FIRST MIDDLE LAST Frank George Sharpe			15. MOTHER'S MAIDEN NAME Jemima			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Teacher Education		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-01-7237			17. INFORMANT Alan Taylor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860			19. DUE TO, OR AS A CONSEQUENCE OF (b),			20. ADDRESS 4414 Highboro Drive Mt. Airy, MD 21771		
			21. DUE TO, OR AS A CONSEQUENCE OF (c),			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized ASCVD								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>D. Miles Jr.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANGER, DONALD M.D.			22e. ADDRESS 55 JACKSON ST, LONACONING MD. 21539			22f. DATE SIGNED 9.14.83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/14/83			23c. NAME OF CEMETERY OR CREMATORIAL Fbg. Mem. Park		
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.			ADDRESS LaVale, MD			25. DATE READY FOR REGISTRAR TO REGISTER SIGNATURE SEP 15 1983 <i>John J. Hafer</i>		
BP _____								
DHMH - 16 50M 4/82 (VRA 15, 4)								

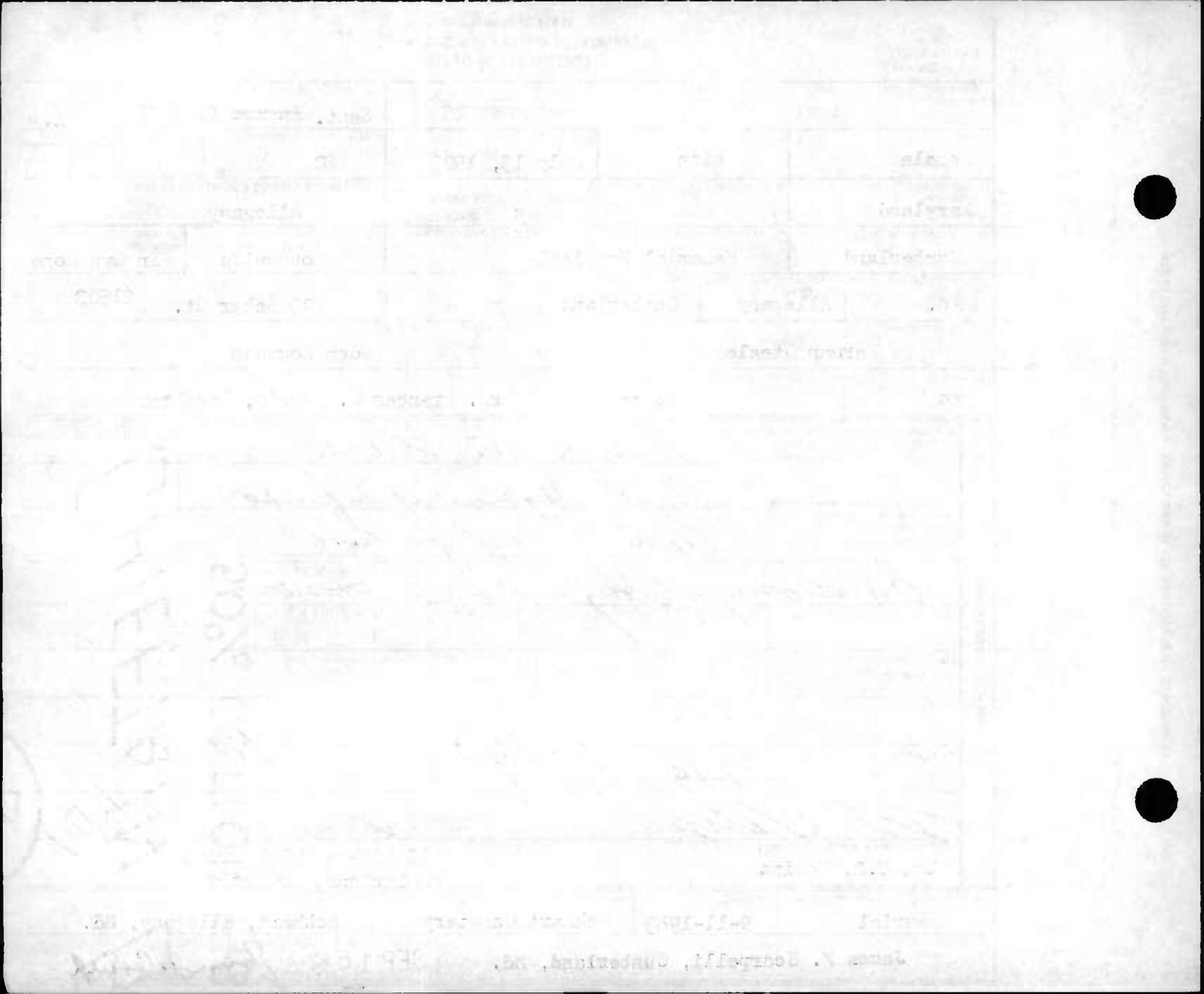


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22893
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
ANNA G. GRABENSTEIN						Sept. August 8, 1983			8:50 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		July 15, 1903		80			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE <small>COUNTRY</small> Maryland		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY In Own Home			
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 703 Baker St.		21502
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Herman Steele					Edna Logsdon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO		212-01-9815		Mrs. Frances J. Norris, Daughter						
18 CAUSE OF DEATH (Enter only one cause per line for item 1b, 1c and 1d.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cardiogenic shock</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <i>5849</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial Infarction</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute renal failure</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cardiomegaly - Toxic Stevens</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		9/8/83		9/6/83		to 9/8/83		19 83		that (I) (we) last
22b. SIGNATURE <i>Dr. V.R. Felipa</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		DATE SIGNED <i>9/8/83</i>
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. V.R. Felipa		22d. ADDRESS 925 Bishop Walsh Drive Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-1983		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Eckhart Cemetery		23d. LOCATION CITY OR TOWN Eckhart, Allegany, Md.		COUNTY		STATE
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>						

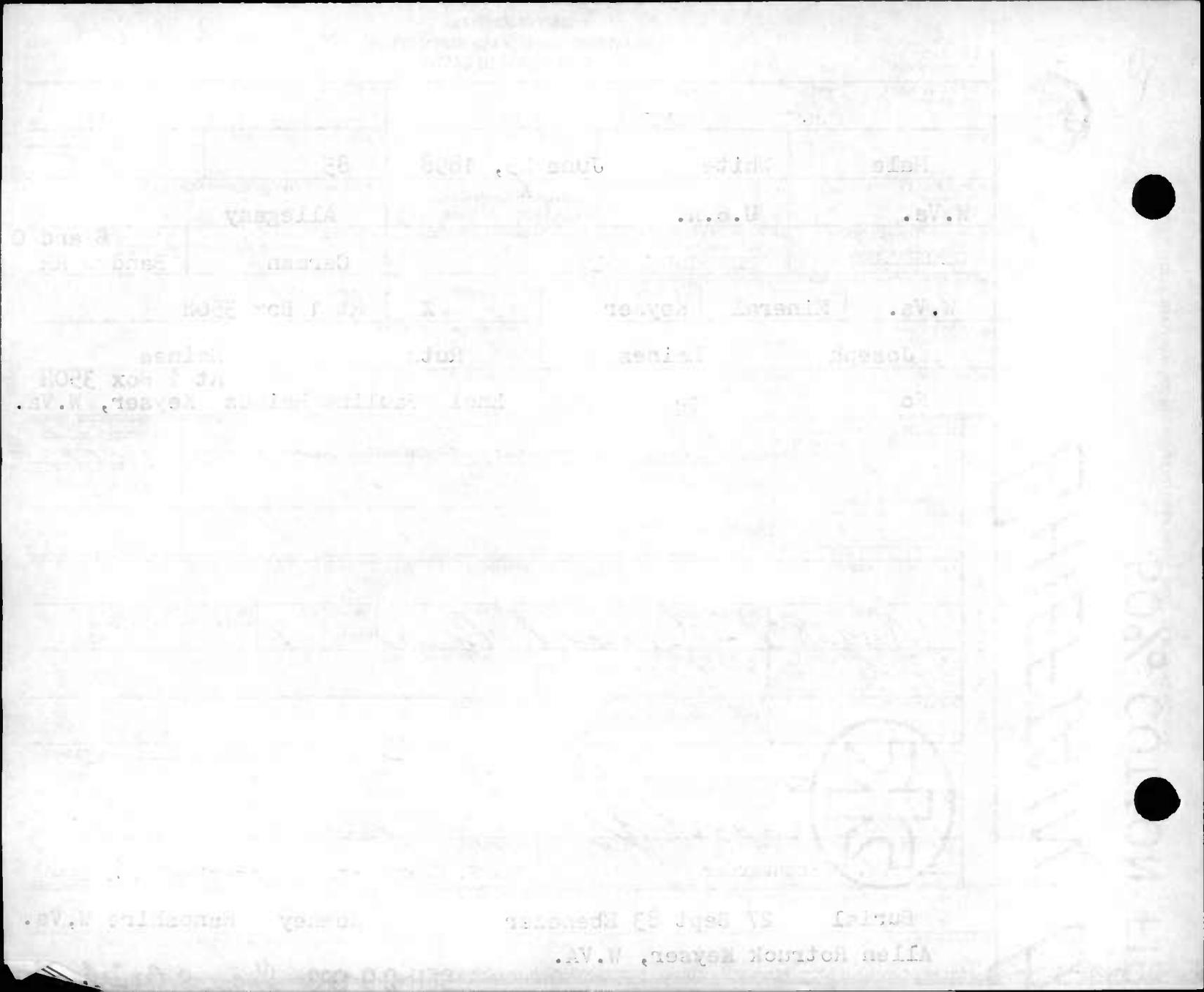


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed in full.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22894				
1 - FOR STATE REGISTRAR											REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
JOHN SNYDER HAINES						September 24, 1983						A 4:19 M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		June 25, 1898			85			YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
W.Va.		U.S.A.					Allegany									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS INDUSTRY								
CUMBERLAND		MEMORIAL HOSPITAL			Carman			Railroad								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
W.Va.		Mineral		Keyser						Rt 1 Box 350H 99999						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
		Joseph		Haines				Ruth		Haines						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No		705-09-7141			Enola Pauline Haines Keyser, W.Va.			Rt 1 Box 350H								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular disease</i> , <i>last year</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
May 83		Stomach Cancer			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>23 Sept 83</i> to <i>24 Sept 83</i> , that he/she lost soul the deceased alive as <i>19 83</i> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did not view the body after death.																
22b. SIGNATURE <i>Dr. F.W. Miltenberger</i>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 24 Sept 83								
22f. PHYSICIAN'S NAME (TYPE OR PRINT)					22g. ADDRESS			122 S. Centre Street Cumberland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE			
Burial		27 Sept 83					Romney			Hampshire			W.Va.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Allen Rotruck Keyser, W.VA.																
SEP 20 1983												<i>Jeanne Smith</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						83 22895		
1 - FOR STATE REGISTRAR			REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST CHESTER	MIDDLE JOSEPH	LAST HANLIN	2a. DATE OF DEATH SEPTEMBER 5, 1983	2b. HOUR 9:22 P.M.	
3. SEX Male			4. RACE White	5. DATE OF BIRTH July 2 nd 1983		6. AGE (IN YEARS LAST BIRTHDAY) 79 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE Mt. Storm WVA			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION Orchard Wker		
13a. STATE W. Va.			13c. CITY OR TOWN Morgan Paw Paw	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1 Box 31 99999		
14. FATHER'S NAME Joseph Neely Hanlin			15. MOTHER'S MAIDEN NAME Sarah Esther Cosner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 236-50-1366			17. INFORMANT Mrs Shirley R. Hanlin, Paw Paw, W.Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant lymphoma</u> . DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cachexia, dysphagia, organic brain syndrome</u> .								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2028</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Cachexia, dysphagia, organic brain syndrome</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>DR. RANJITHAN</u>			22c. DEGREE MD, ABIM ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/6/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN			22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/9/1983			23d. LOCATION CITY OR TOWN Paw Paw, (Morgan) W. Va.		
24 FUNERAL DIRECTOR NAME Johnson Funeral Home, Berkeley Spgs. W. Va.			25a. DATE REC'D. BY REGISTRAR SEP 9 1983			25b. REGISTRAR'S SIGNATURE <u>George Casper</u>		

20% COTTON



100% POLYESTER BACK

100% POLYESTER FABRIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	REG. NO.	2b. HOUR
ELIZABETH M. HARDESTY					SEPTEMBER 23, 1983				4:15A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 4	DAY 28	YEAR 98	6. AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS 85	IF UNDER 24 HRS DAYS YRS	MD.	7. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	9b. CITY OR TOWN OF DEATH Cumberland	9c. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			9d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			9e. COUNTY OF DEATH ALLEGANY COUNTY,	10. CITY OR TOWN OF DEATH Cumberland	
11a. STATE Md 21502	11b. COUNTY Allegany	11c. CITY OR TOWN Bowling Green	11d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	11e. STREET ADDRESS 12513 Bowling Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	12c. ADDRESS Bowling Green, Md			
14. FATHER'S NAME FIRST John	MIDDLE J.	LAST Smith	15. MOTHER'S MAIDEN NAME FIRST Lucy	MIDDLE --	LAST Buckalew					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. --	16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest	16d. DUE TO, OR AS A CONSEQUENCE OF (b) Cardio pulmonary arrest	16e. DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary edema	16f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I coronary artery disease, old myocardial infarction										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <input checked="" type="checkbox"/> 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9122	21f. LOCATION STREET 9123	CITY OR TOWN 85	COUNTY 9123	STATE 85					
22a. I certify that (I) (this hospital) attended the deceased from 9/12/83 , to 9/23/83 , that (I) (we) lost saw the deceased alive on 9/12/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 9/23/83				
22b. SIGNATURE Wally Hijab	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLY HIJAB, M.D.	22e. ADDRESS 909-A SETON DRIVE, CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-25-83	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial	23d. LOCATION CITY OR TOWN Cumberland	23e. COUNTY Allegany	23f. STATE Md					
24. FUNERAL DIRECTOR NAME George-Upchurch funeral Home P.A.	24b. ADDRESS 202 Greene St.	24c. DATE REC'D. BY REGISTRAR SEP 28 1983	24d. REGISTRAR'S SIGNATURE John J. Carroll							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

HINKLE FUNERAL HOME DAVIS, WV 26260			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 3 2 2 8 9 1						
						REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
GLADYS		MARIE	HARSH		SEPTEMBER 15, 1983					1:00A M		
3. SEX		4. RACE		5. DATE OF BIRTH								
Female		White		March 5, 1903		MONTH	DAY	YEAR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		<input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
WV.		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		ALLEGANY COUNTY, MD.		
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
ALLEGANY COUNTY, MD.		Cumberland		SACRED HEART HOSPITAL		housewife				Home		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
WV.		Preston		Aurora		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural		99999		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		Henry	E.	Smith	Minnie						LAST Hauser	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		233-62-8516		Harold Harsh		Rt. #1 Aurora, Wv.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4140 (b) <i>Coronary Heart Disease</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S.C.Y.D</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Congestive Cardiomyopathy. C. HF</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
VINCENT, CLARENCE, M.D.		909-B SETON DRIVE, CUMBERLAND, MD 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		Sept. 17, 1983		Stemple Ridge		Aurora, Preston		WV.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Lester R. Hinkle Davis, WV.				SEP 23 1983								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

KIGHTFUNERAL HOME
1 - STATE 309 DECATUR ST.
REGISTRAR CUMBERLAND, MD. 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 22898

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
BEULAH IZETTA HUFF						SEPTEMBER 23, 1983				8:45P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH DAY YEAR July 27, 1898		85 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? XXXX NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 220 Sommerville Ave. 21502					
14. FATHER'S NAME FIRST Christopher		MIDDLE Prices		LAST		15. MOTHER'S MAIDEN NAME FIRST Lillian		MIDDLE		LAST Kerns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-42-4853		17. INFORMANT Charles W. Huff, Jr., Cumberland, Md.		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest (standstill) 4100 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Cardiacogenic shock; Left bundle branch block													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 83 to 9/23 , 19 83 , that (I) (we) last saw the deceased alive on 9/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Wally S. Kight, M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/24/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIJAB, WALLY M.D.		22e. ADDRESS 909-A SETON DR. CUMBERLAND, MD. 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 27, 83		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Mem. Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, MD.		COUNTY		STATE			
24. FUNERAL DIRECTOR William G. Kight, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR OCT 3 1983						25b. REGISTRAR'S SIGNATURE John G. Coniglio					

2023 RELEASE UNDER E.O. 14176

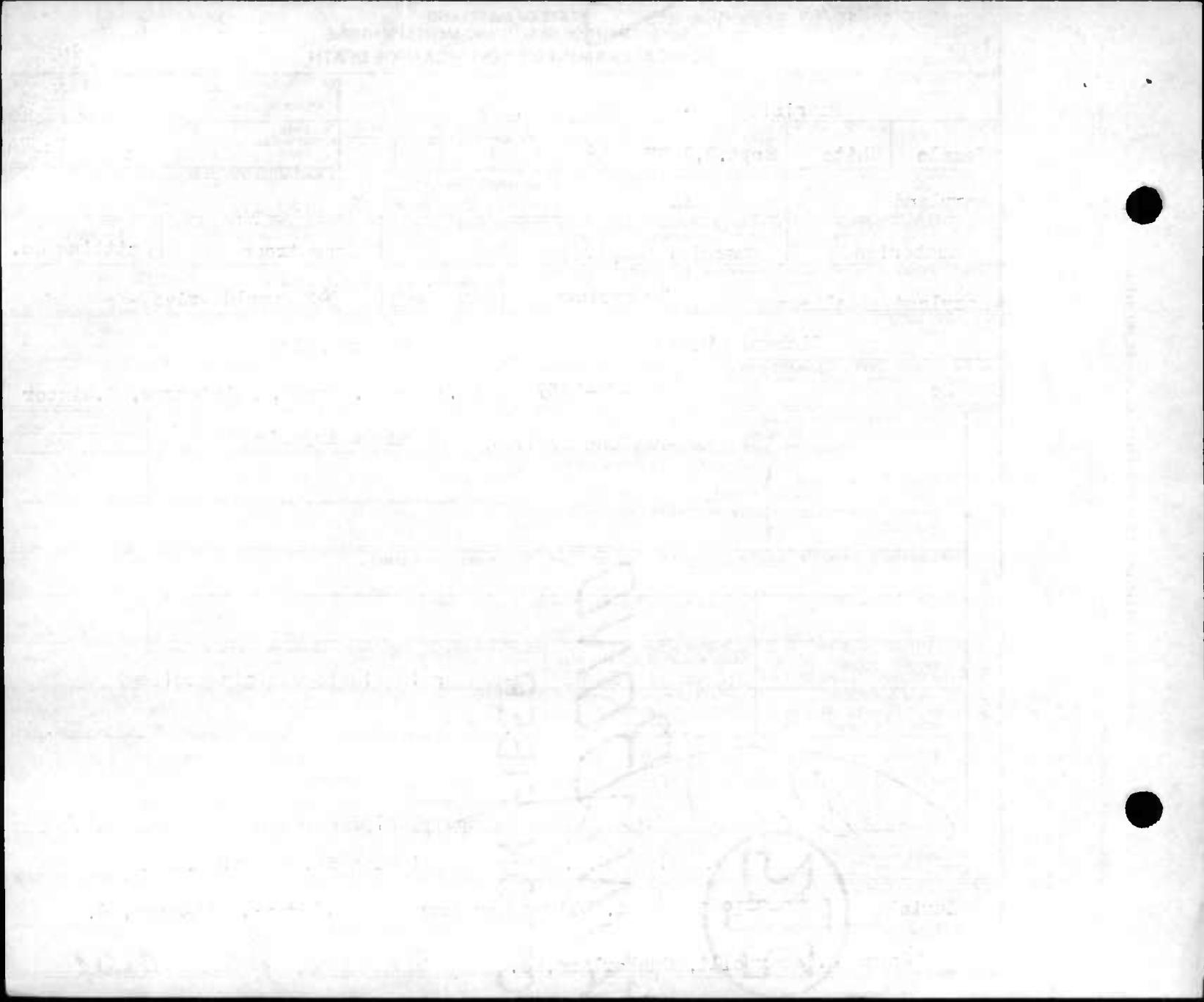
J. M. YOUNG, SAUER

ANSWER • Page Composition 59

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

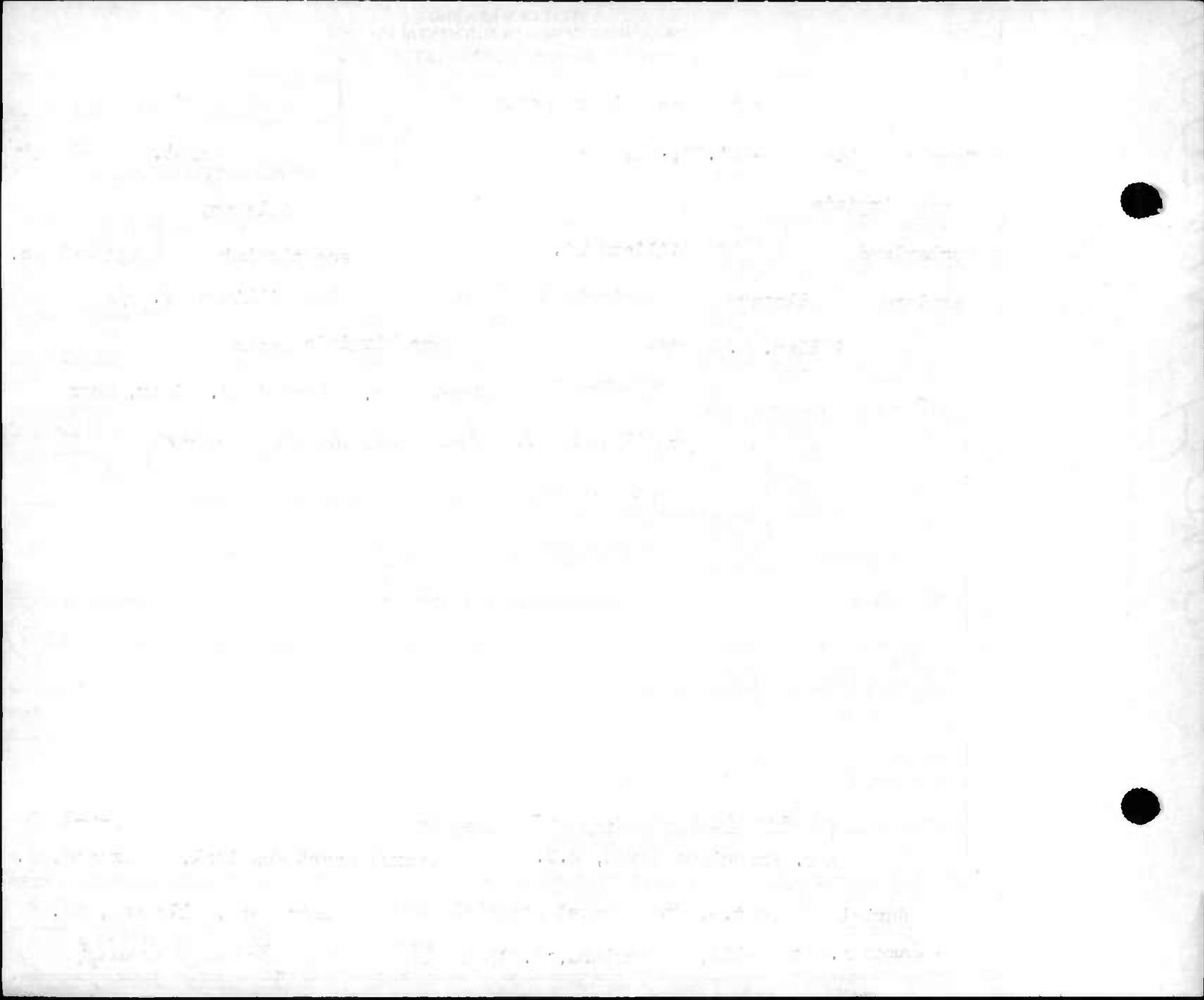
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22899		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE KNOWN <input checked="" type="checkbox"/> MONTH			DAY	YEAR	2b HOUR	
Patricia E.					Imes	OF ESTI- DEATH MATED			9	5 1983	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR
Female	White	Sept. 3, 1947	36			9 5 1983			2:57A	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA						Allegany County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital			Seamstress			Knitting Co.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Allegany		Cresaptown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		342 Harold Drive 21502				
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Richard Kinser					Iva May Twigg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		218-50-0359		Mrs. Joyce L. Grubb, Flintstone, Md. Sister								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lacerations of liver</u> Multiple injuries 8151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
XXOR		2:05PM 9 5 1983			Passenger in single vehicle accident							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
		street			Rt. 28					W. Va		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Donald J. Smith</u>												
TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS			DATE SIGNED 9/5/83				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Oldtown, Allegany, Md.			STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR 'SEP 13 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>				
James F. Scarpelli, Cumberland, Md.												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22900						
												REG. NO.						
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
		Betty Mae Kiser James												9 5	19	83	8 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female		White		Sept. 20, 1918			64 yrs.							Sept. 6, 1983	19	83	2:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia														Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			496 Williams St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland											Receptionist			Optical Co.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21502					
Maryland		Allegany		Cumberland						496 Williams St.								
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
William		E.			Spotts			Mae Virginia Leake										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			232-26-0435			17. INFORMANT			ADDRESS							
								Charles Wm. & Francis S. Kiser, Sons										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) <i>Disease</i> (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
												YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____												
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Francisco Reyes, M.D. Deputy MEDICAL EXAMINER						
												DATE SIGNED 9-6-1983						
EXAMINER'S NAME (TYPE OR PRINT)			Dr. Francisco Reyes, M.D.									ADDRESS Sacred Heart Hospital, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY STATE						
Burial			Sept. 9, 1983			Sunset Memorial Park			Cumberland, Allegany, Md.									
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md. 21502												25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 'SEP 13 1983 John J. Caneff						



B
may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SCARPELLI FUNERAL HOME
FOR STATE 108 VIRGINIA AVENUE
REGISTRAR CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 22901

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
BETTY JEAN KEGG						SEPTEMBER 25	1983	3:15 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 29, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
								YRS.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME				
13a. STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 817 CALVIN ST. 21532		
14. FATHER'S NAME MICHAEL V. FACEY				15. MOTHER'S MAIDEN NAME NORA MC DONNELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 187-26-7256		17. INFORMANT MR. WILLIAM KEGG (HUSBAND)		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749		IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Aspiration pneumonia b7		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		{ DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent ca of breast = br. labored								
		{ DUE TO, OR AS A CONSEQUENCE OF (c) pulm. miliary metastasis & d75/kgma								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-15 1983 , to 9-25 1983 , that (I) (we) last saw the deceased alive on 9-24-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Mehanna		22c. DEGREE MD - ATTENDING PHYSICIAN		22d. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 9-26-83				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MEHANNA		22g. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MARYLAND								
23a. FUNERAL CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/29/83		23c. NAME OF CEMETERY OR CREMATORIUM SS. PETER & PAUL CEM.		23d. LOCATION CITY OR TOWN CUMBERLAND, ALLEGANY		23e. COUNTY 21502		
24. FUNERAL DIRECTOR NAME JAMES F. SCARPELLI, CUMBERLAND, MD.		25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE SEP. 29 1983 John J. Scarpell								

ROBERT ELLSWORTH
108 ALBANY ST.
CHICAGO, IL 60602

A.D.L. 1981, 25 DECEMBER

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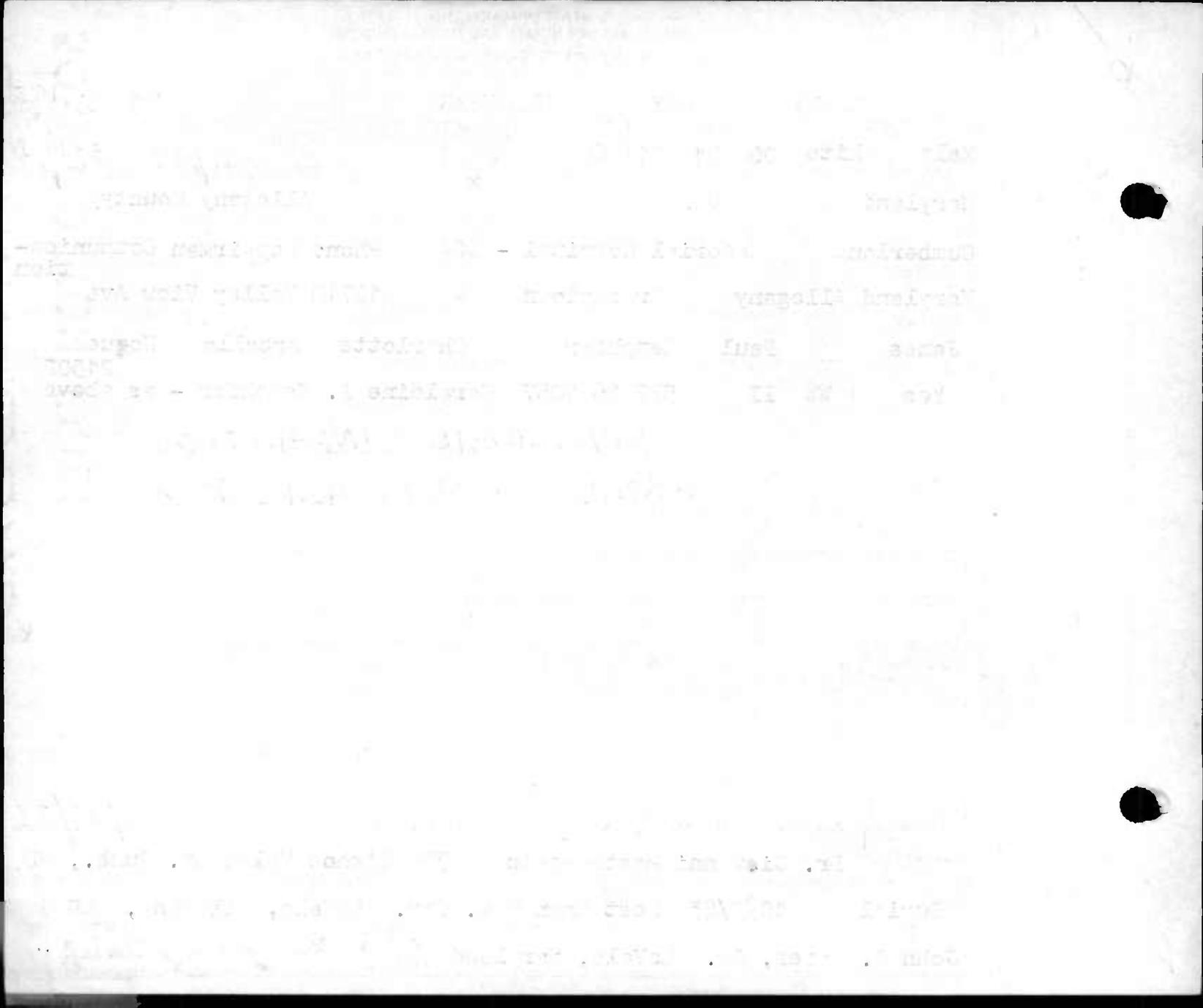
RECEIVED 12/25/81

RECEIVED 12/25/81 10:12 AM 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22902		
1. DECEASED NAME (TYPE OR PRINT)			FIRST DEWEY	MIDDLE RAY	LAST KEMPHFER	2a. DATE KNOWN OF DEATH ESTI- MATED				MONTH DAY YEAR 9/29 1983	2b. HOUR 10:30 M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 62 yrs	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9/29 1983				MONTH DAY YEAR 10:30 M	2d. HOUR 10:30 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital - DOA			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Phone Repairman				12b. KIND OF BUSINESS OR INDUSTRY Communication					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		14. FATHER'S NAME FIRST James		MIDDLE Paul	LAST Kemphfer	15. MOTHER'S MAIDEN NAME FIRST Charlotte	MIDDLE Arbella	LAST Hogue
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. IF YES, GIVE WAR OR DATES WW II		16d. SOCIAL SECURITY NO. 577 26 1067		17. INFORMANT Geraldine A. Kemphfer - as above		ADDRESS 21502 12718 Valley View Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARIERIO - SCEROTIC HEART DISEASE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dr. Giovanni Mastrangelo</i> M.D. MEDICAL EXAMINER												TITLE (SPECIFY) Dr. Giovanni Mastrangelo	DATE SIGNED 9/29/83	
EXAMINER'S NAME (TYPE OR PRINT) Dr. Giovanni Mastrangelo			ADDRESS 772 Bishop Walsh Dr. Cumb., MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/3/83			23c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Mem. Gar.			23d. LOCATION CITY OR TOWN LaVale, Allegany, MD		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.			ADDRESS LaVale, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 4 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>			
DHMH-17 (VR A15 ME (5)) 15M 2/80														

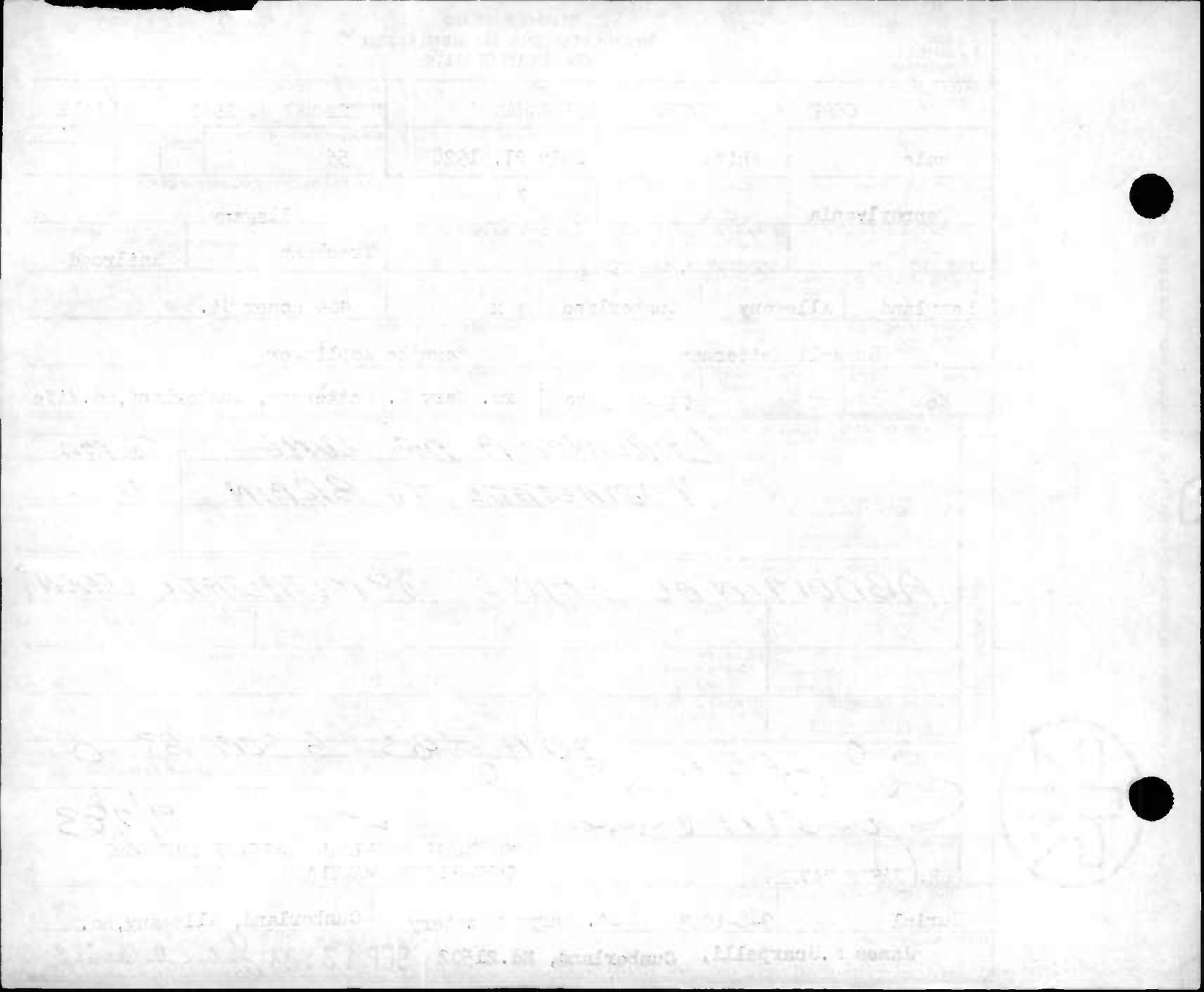


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	22903						
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
CHARLES ALTON KETTERMAN						SEPTEMBER 6, 1983						1:12 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male		White		JULY 21, 1928		55			MONTHS		DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Pennsylvania		USA				Allegany											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
CUMBERLAND		MEMORIAL HOSPITAL		Trackman			Railroad										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Allegany		Cumberland		404 Homer St. 21502											
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST								
		Russell	Ketterman		Bernice Keplinger												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		723-12-5879		Mrs. Mary Z. Ketterman, Cumberland, Md. Wife													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		CARCINOMA OF LUNG										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		3 MO															
(b) METASTATIC TO BRAIN		11															
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 30 Aug 1983 to 6 Sept 1983, that (I) (we) last saw the deceased alive on 6 Sept 1983, and that (my) (our) opinion death occurred on the date and hour and from the causes stated below. (We) (did) not view the body after death.																	
22b. SIGNATURE James M. Raver		DEGREE															
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/9/83													
DR. JAMES RAVER		MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
Burial		9-8-1983		St. Marys Cemetery		Cumberland		Allegany		Md.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 13 1983 John G. Canfield															
James F. Scarpelli, Cumberland, Md. 21502																	

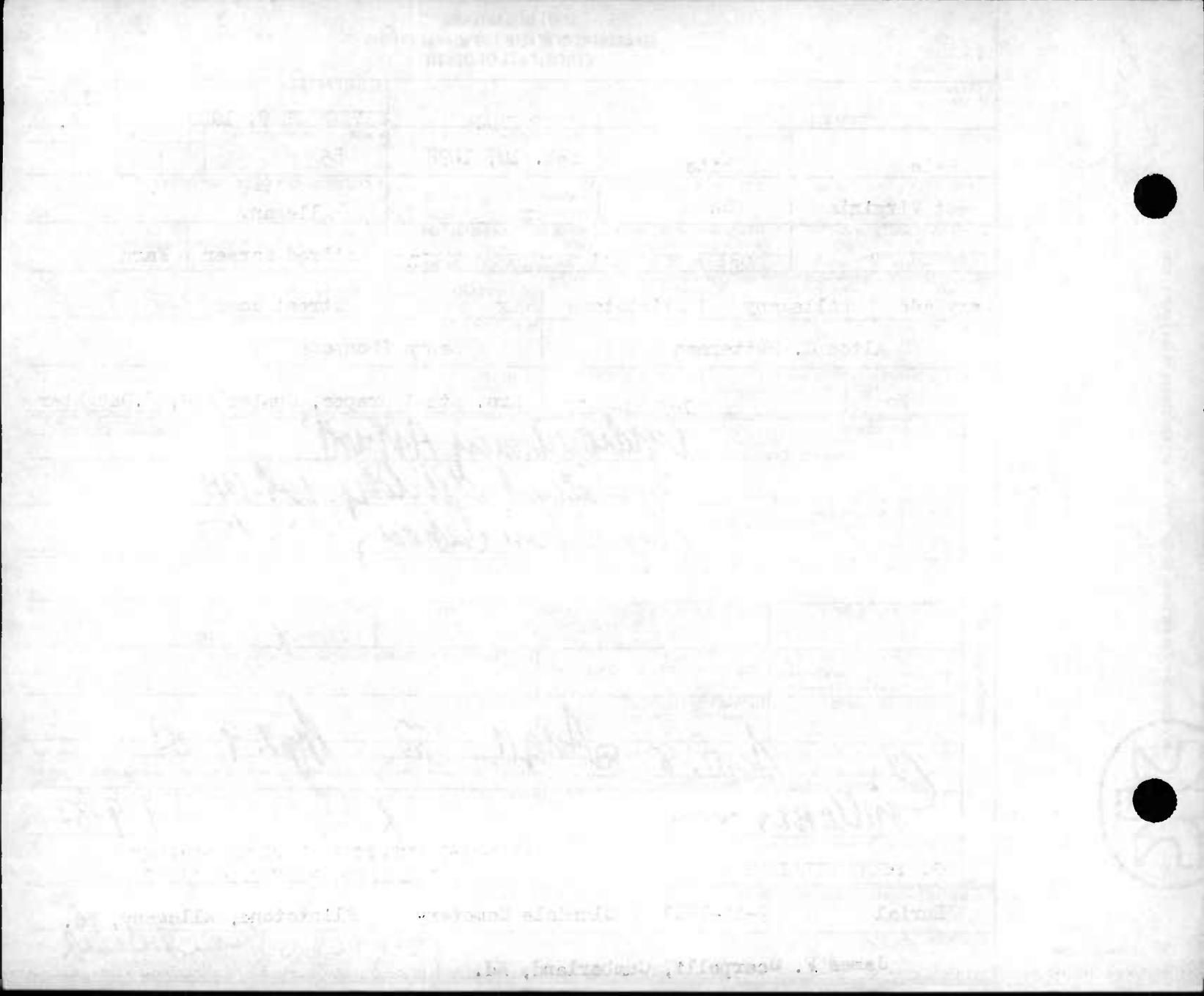


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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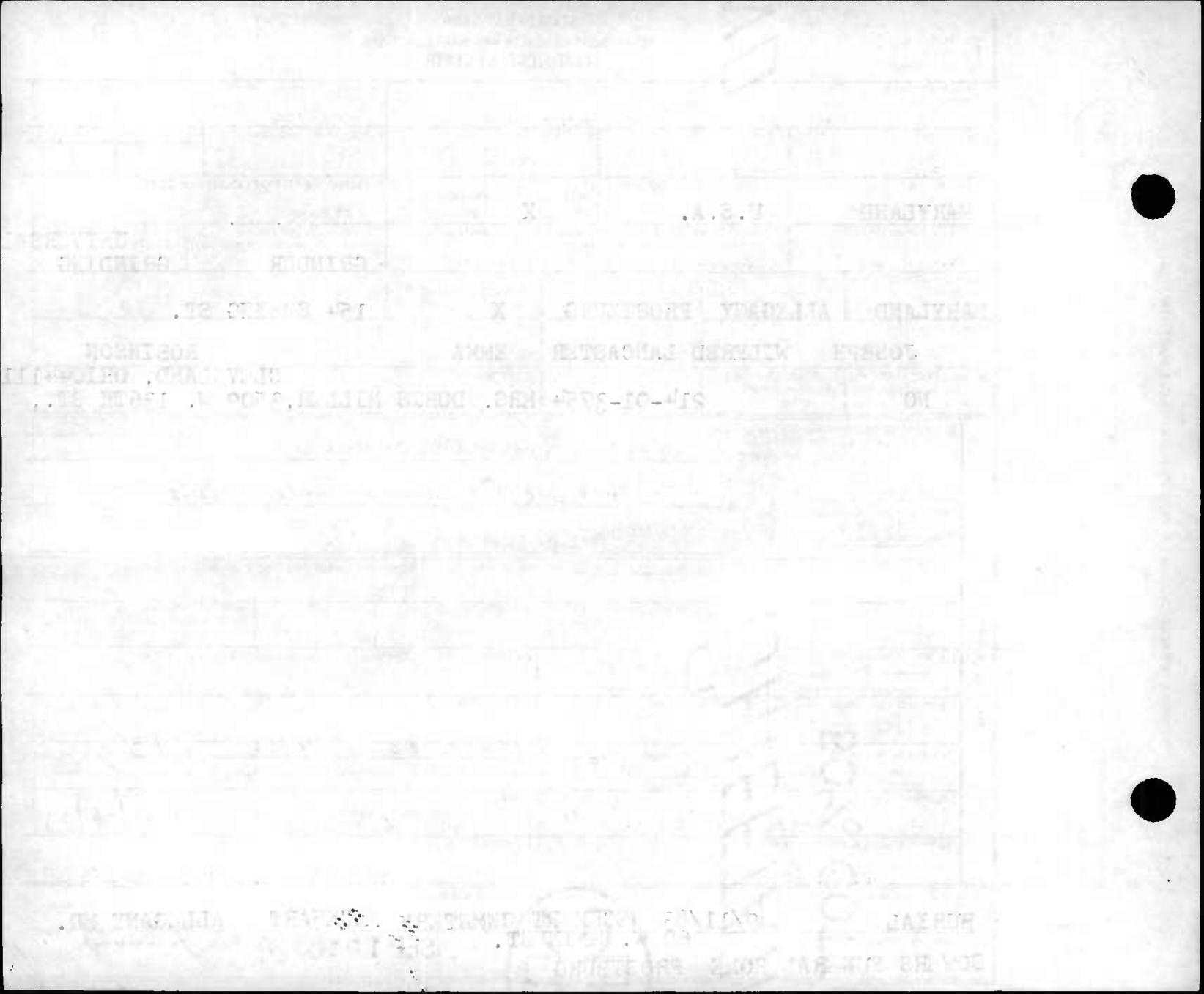
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22904	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR 11:00 A.M.	
TRVIN			KETTERMAN			SEPTEMBER 9, 1983							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Feb. 10, 1898 ¹⁸		85			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farm						
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Street Road		21530			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 705-14-0057		17. INFORMANT Mrs. Ethel Grapes, Cumberland, Md. Daughter		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for each part.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3310 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Aug. 8, 1983			21f. LOCATION STREET			21g. CITY OR TOWN CITY OR TOWN				
22a. I certify that (I) (this hospital) discontinued treatment from the deceased alive on 1983, to 1983, that (I) (we) last saw (he) (she) (it) (we) alive on 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not see the body after death.			22b. SIGNATURE Terry Williams			22c. DEGREE			22d. DATE SIGNED 9-9-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS			22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-12-1983			23c. NAME OF CEMETERY OR CREMATORIAL Glendale Cemetery			23d. LOCATION CITY OR TOWN Flintstone, Allegany, Md.				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 15 1983							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use on the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22905	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ray W Lancaster						9/8/83						2:30p M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			White			MONTH DAY YEAR			76 YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Allied Co.			MD.	
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GRINDER			12b. KIND OF BUSINESS OR INDUSTRY UNIVERSAL GRINDING				
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 154 SPRING ST. 21536	
14. FATHER'S NAME JOSEPH			MIDDLE WILFRED			LAST LANCASTER			15. MOTHER'S MAIDEN NAME EMMA			ROBINSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-3754			17. INFORMANT			ADDRESS CLEVELAND, OHIO 44111				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nepato - Renal Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatostatic Carcinoma to liver, lungs. (c) Carcinoma of Colon													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9108 19 83			21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY COUNTY STATE STATE			9/08 83 to 9/08 83				
22a. I certify that (I) (this hospital) attended the deceased from 9/08 83 to 9/08 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Dr. A. Roque</i>			22c. DEGREE DR. ROQUE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/08/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Roque			22e. ADDRESS Broadway St., Frostburg, Md 21532										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/11/83			23c. NAME OF CEMETERY OR CREMATORIAL ECKHART CEMETERY			23d. LOCATION CITY OR TOWN ECKHART			CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME SOWERS FUNERAL HOME			ADDRESS 60 W. MAIN ST... FROSTBURG			DATE RECEIVED BY PROSTORIAL REGISTRAR'S OFFICE SEP 15 1983							

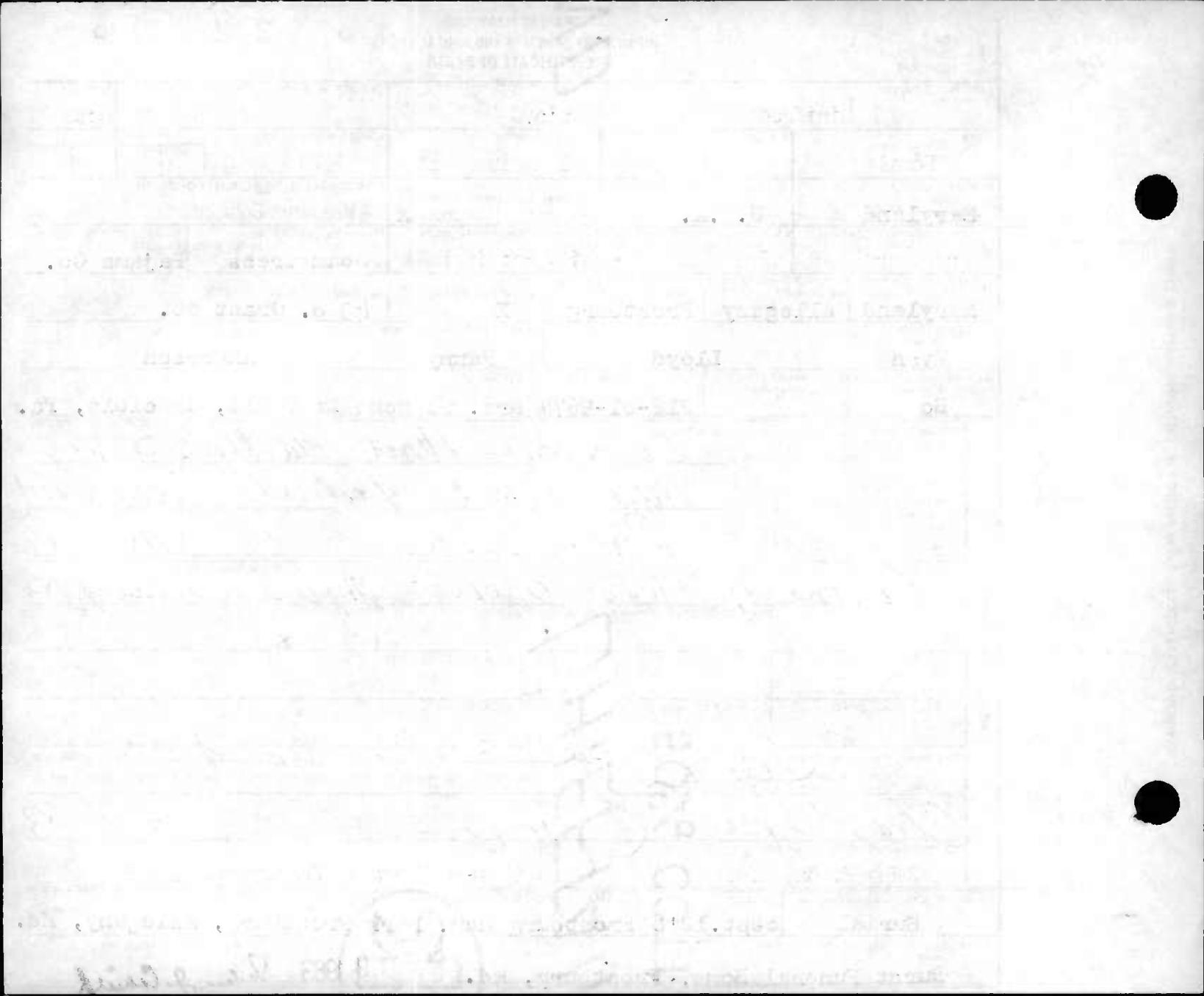


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

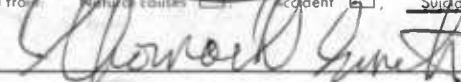
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

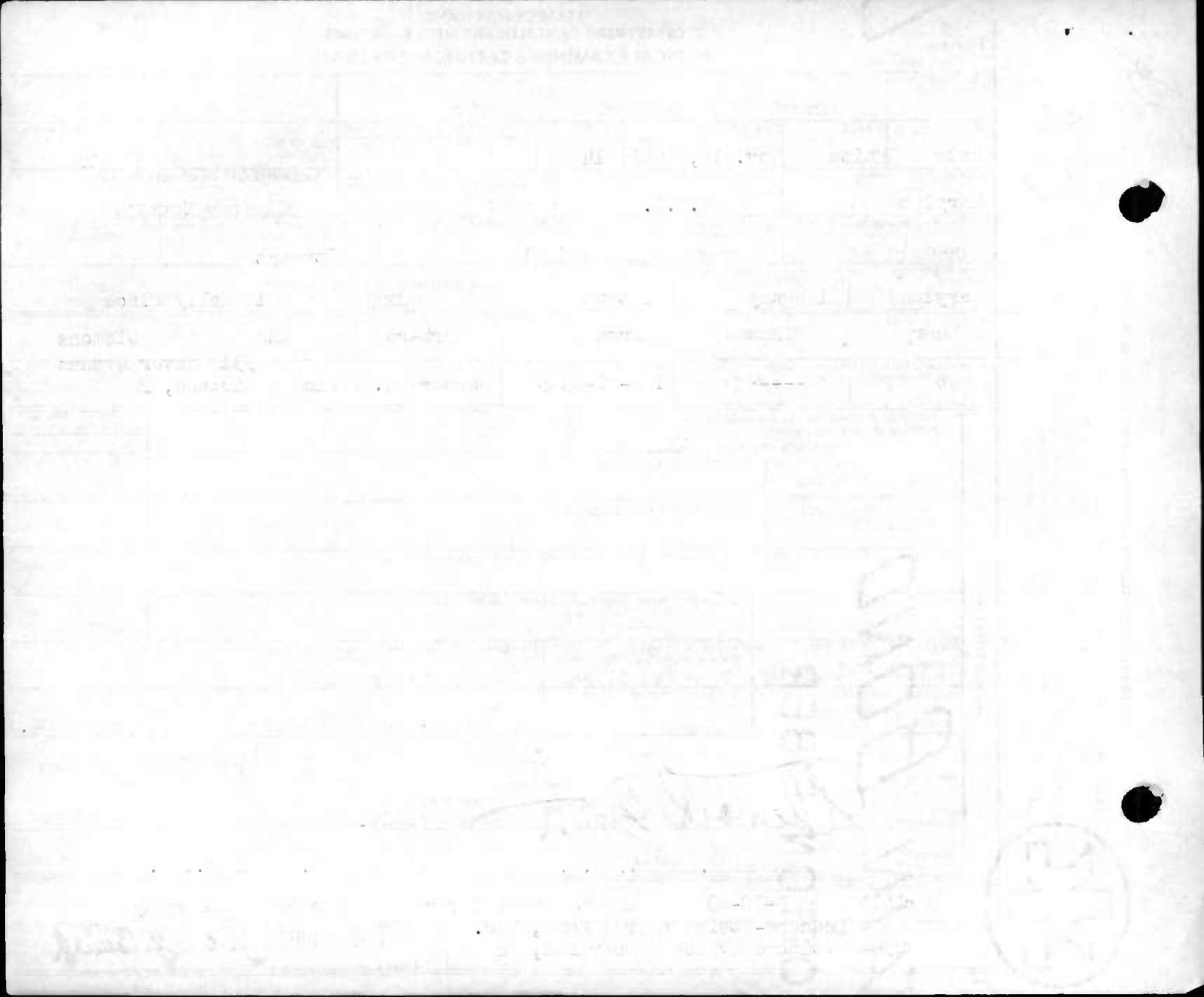
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22906					
												REG. NO.					
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			Winifred			H.			Lloyd			9	9	83	3:55 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			MONTH DAY YEAR			70			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A.						Allegany County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Frostburg			Frostburg Community Hospital			Seamstress			Pajama Co.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21532		
Maryland			Allegany			Frostburg						43 S. Grant St.					
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			LAST					
Evan						Lloyd			Fanny			Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			212-01-9671			Mrs. Blanche De Vault, Crucible, Pa.											
18 CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Renal Failure</i>												<i>one week</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>												<i>one week</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Coronary Heart Disease - Myocardial infarction</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY TOWN			COUNTY	STATE				
22a. I certify that (I) (he) attended the deceased from <i>Sept 3</i> , 19 <i>83</i> , to <i>Sept 9</i> , 19 <i>83</i> that (I) (we) last saw the deceased alive on <i>Sept 7</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Chang H. Oh</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9-12-83</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chang H. Oh, M.D.			22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 12 '83			23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Mem. Park			23d. LOCATION CITY OR TOWN Frostburg			COUNTY Allegany	STATE Md.				
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR Sep 19 1983			25b. REGISTRAR'S SIGNATURE <i>Debra J. Conner</i>								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WHILE PAGE 2 SHOULD BE FILED, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22901			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
Joseph Leonard Marks						<input checked="" type="checkbox"/>	9	27	1983	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 10AM M
Male	White	Nov. 10, 1968			14 yrs.		<input checked="" type="checkbox"/>	9	27	1983	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Allegany County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Sacred Heart Hospital					Student			21055			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12 Kelly Place					
14. FATHER'S NAME Henry		Thomas		Marks		15. MOTHER'S MAIDEN NAME Barbara		16. ADDRESS 531 Beaver Avenue Midland, PA		Cllemons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO 196-62-0345		17. INFORMANT Barbara A. Lewis									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY ? P.M. 9 27 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Subject hanged self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 12 Kelly Place			CITY OR TOWN Oldtown	COUNTY Allegany	STATE Md.		
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural death <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER												DATE SIGNED 9/27/83	
ACTUAL SIGNATURE 													
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9-30-83		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE MD		
24. FUNERAL DIRECTOR NAME		Leisure-Stein Funeral Home, Inc. 230 Baltimore Avenue			ADDRESS Cumberland, Md.			25a. DATE REC'D BY REGISTRAR Oct 4 1983		25b. REGISTRAR'S SIGNATURE 			
BP		DHMH - 17 (VR A15 ME (5))			20M 4/B2								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Silcox-Merritt Funeral Home STATE OF MARYLAND 1- FOR 404 Decatur Street DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR Cumberland, MD 21502 CERTIFICATE OF DEATH						8322408
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.
Frank Leo McCagh						
3. SEX Male			4. RACE White	5. DATE OF BIRTH Month Day Year Feb. 7, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	2a DATE OF DEATH MONTH DAY YEAR September 21, 1983 12:15 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.	
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			
13a. STATE Md.			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Francis			MIDDLE Leo	LAST McCagh	15. MOTHER'S MAIDEN NAME FIRST Margaret	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170-03-3411			
17. INFORMANT ADDRESS Mrs. Catherine McCagh 834 Windsor Rd. Cumberland, Md. 21502						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Cardiac Arrest			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b), Acute myocardial infarction			
			DUE TO, OR AS A CONSEQUENCE OF (c), Coronary artery disease.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE C. J. Vincent M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT M.D. Baljeet Mahal, M.D.			22d. DATE SIGNED 22e. ADDRESS 909-B Seton Drive Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 23, 1983		23c. NAME OF CEMETERY OR CREMATORIAL S.S. Peter & Paul Cemt.		
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Ser.		24b. ADDRESS 404 Decatur St. Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 26 1983 Joe J. Carr		

AM TPO IV 2004

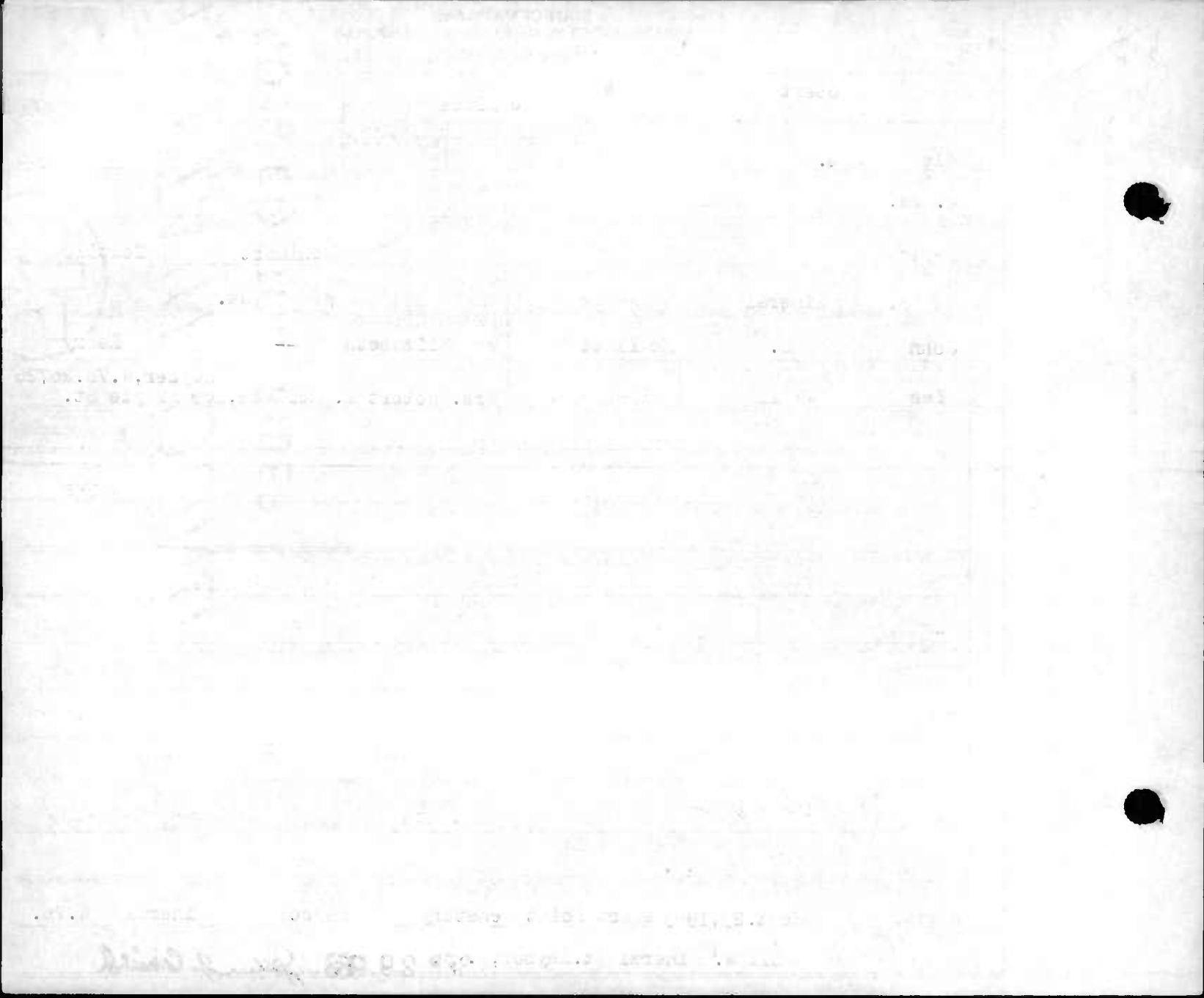
2004
148
145

X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	22409						
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						LAST						2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
		FIRST Robert		MIDDLE Lee		LAST Mc Ilwee						<input checked="" type="checkbox"/>		9-26-83			0645		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Male		Caus.		11-16-10			72 yrs.							9-26-83					0645
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		USA												Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Memorial Hospital										Machinist		Textile					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.									
West Va.		Mineral		Keyser		189 Argyle St.		99999											
14. FATHER'S NAME		MIDDLE John		LAST C.		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
				Mc Ilwee		Elizabeth					217-10-5634		Mrs. Robert L. McIlwee, 189 Argyle St.		Keyser, W. Va. 26726				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm 4416 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
												24 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Coronary artery heart disease. Hypertensive cardiovascular disease												years							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
9-26-83		Ruptured aneurysm										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) M.D. Ast. Dpty			MEDICAL EXAMINER				
ACTUAL SIGNATURE <i>Paul Snow, M.D.</i>		DATE SIGNED 9-26-83																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL						23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		Sept. 29, 1983		Meadow Point Cemetery						Keyser		Mineral		W.Va.					
24. FUNERAL DIRECTOR NAME <i>Howard W. Jr. / Clegg</i>		ADDRESS 111 S. Mineral St. Keyser, W. Va.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>SPP 29 1983 John J. Clegg</i>													
BP _____ 999999																			
DHMH-17 (VR A15 ME (5)) 15M2/80																			

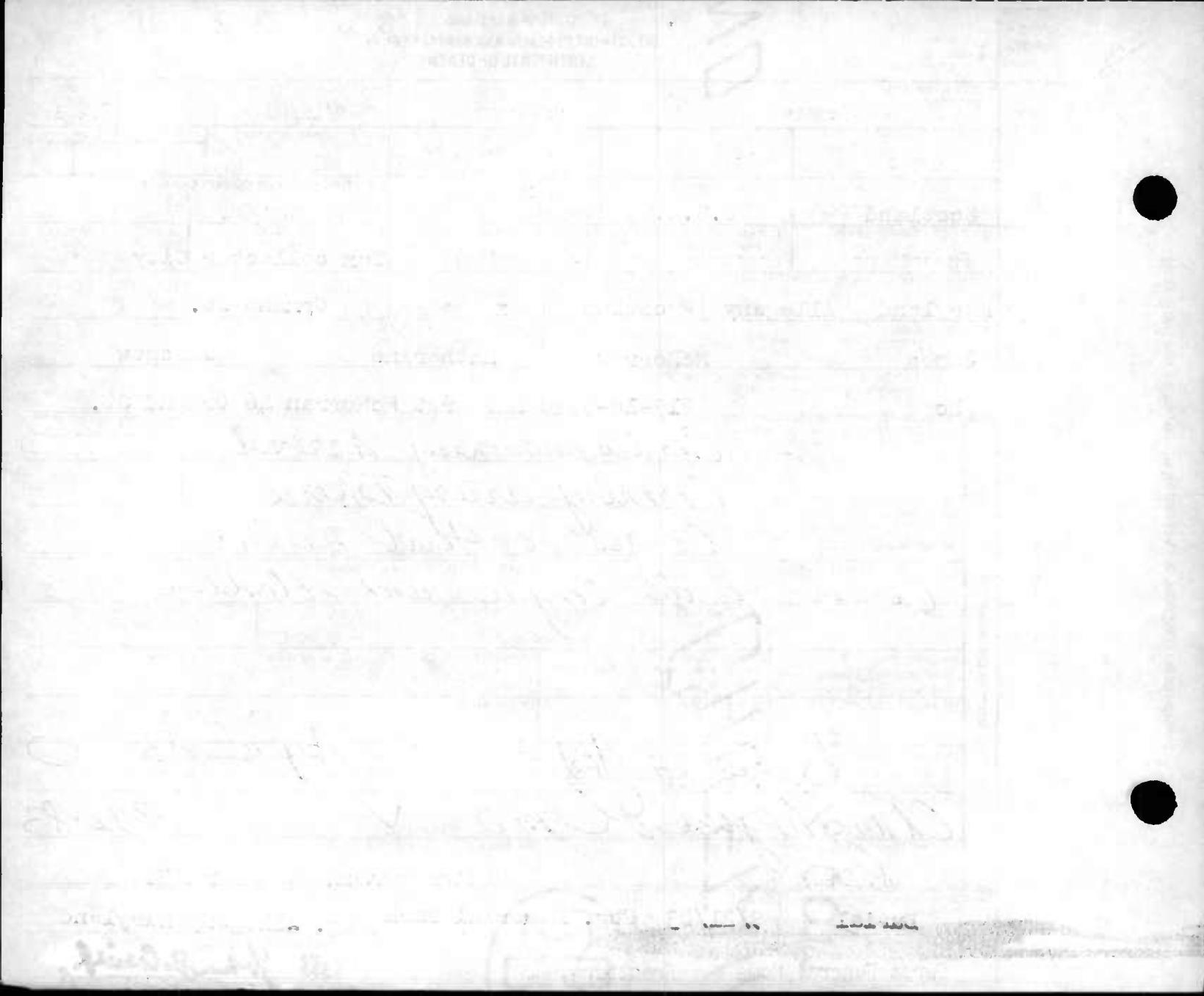


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22910				
											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Thomas			G			McMorran						9/19/83				2:20a M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
male		white		MONTH 2/ DAY 15/ YEAR 02			81			MONTHS YRS.		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Scotland		U.S.A.					Allegany Co.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg		Frostburg Community Hospital										Tax collector		City		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Allegany		Frostburg						46 Ormand St. Q1532						
14. FATHER'S NAME		LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS					
James		McMorran			Katherine			213-10-9690			Margaret McMorran 46 Ormand St.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No								4149			<i>Cardiopulmonary arrest</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF (b) <i>Artery Disease</i>								
								DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Cancer of the tongue and bladder																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 19 1983</i> , 1983, to <i>Aug 26 1983</i> , 1983, that (I) (we) last saw the deceased alive on <i>Sept 19 1983</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Chang Oh MD</i>		22c. DEGREE									22d. DATE SIGNED <i>09-20-83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Chang Oh																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/21/83			23c. NAME OF CEMETERY OR CREMATORIAL Fbg. Memorial Park			23d. LOCATION CITY OR TOWN Fbg. Allegany Maryland			23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Durst Funeral Home		ADDRESS Frostburg, MD						25a. DATE REC'D. BY REGISTRAR SEP 26 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Casper</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in the funeral director's office as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
SCARPELLI FUNERAL HOME
REGISTRAR 108 VA. AVE. CUMBERLAND, MD. 21502
CERTIFICATE OF DEATH

22911

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ALICE H. McMULLEN							SEPTEMBER 24, 1983				5:15P M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 23 1896			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
							87	YRS	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.							
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 826 Buckingham Road 21532					
14. FATHER'S NAME Edward James Hanrahan				15. MOTHER'S MAIDEN NAME Katherine Ryan										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 2L7-10-7433		17. INFORMANT Daniel F. McMullen, Jr. Cumberland, MD			ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>4292</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>BS CVD</i>							<i>20 yr</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>George B. Spiggle MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF <input type="checkbox"/>		PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/27/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE SPIGGLE, M.D.		22e. ADDRESS		912 SETON DRIVE CUMBERLAND, MD. 21502										
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE 9-27-83		23c. NAME OF CEMETERY OR CREMATORIAL SS Peter and Paul			23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE MD			
24. FUNERAL DIRECTOR NAME <i>James F. Scarcelli Cum. Balford, MD</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 29 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>							

118 A.V. V.A. C. C. E. N. A. M. 1970-1971

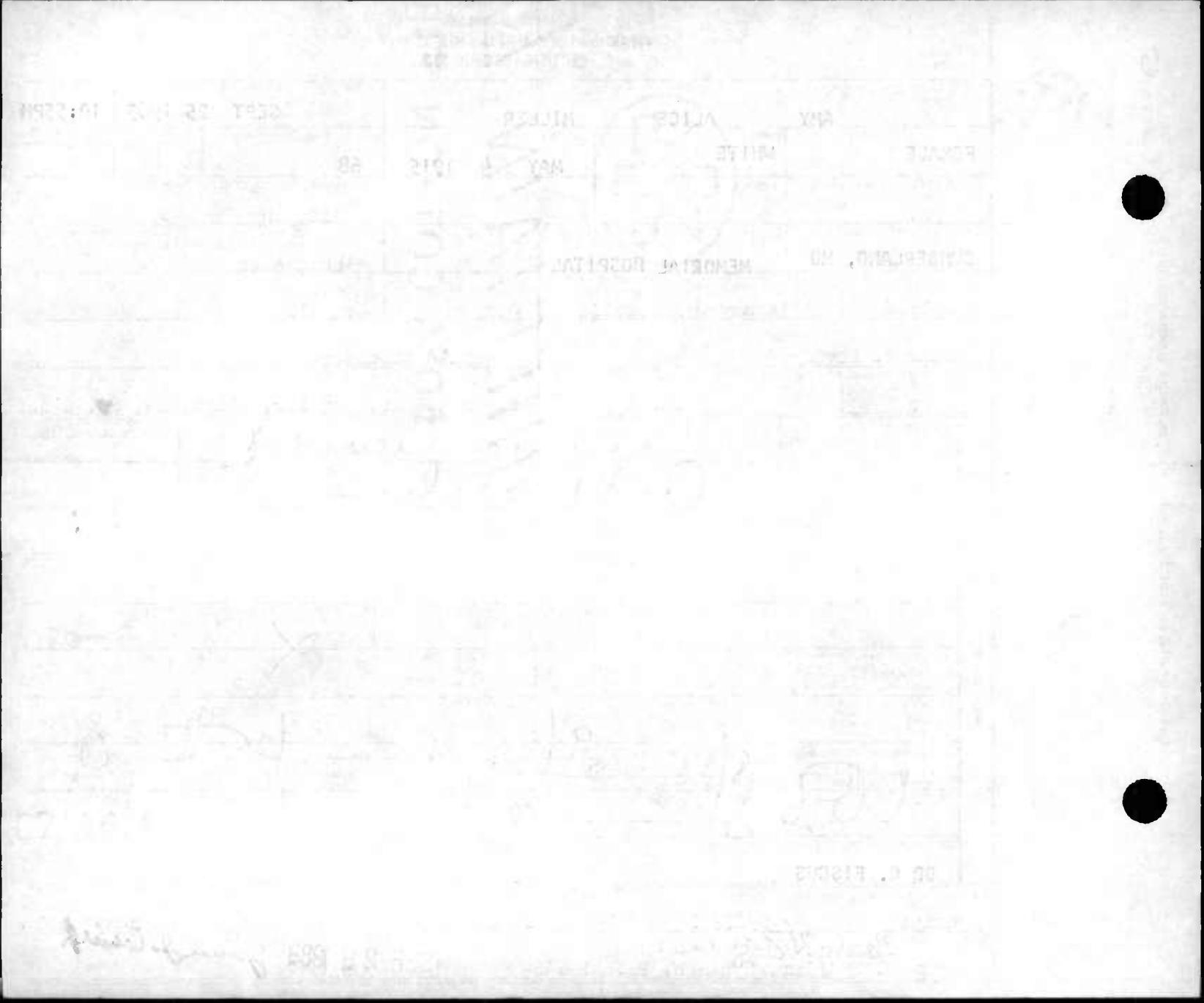
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22912				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	SEPT 25 1983			10:55PM					
AMY ALICE MILLER														
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR MAY 4 1915			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY 21539					
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Ellerslie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST Oscar H. Leydig			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST Bertie Stouffer			13e. STREET ADDRESS Box 115					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 10 1628			17. INFORMANT Arthur Miller, Box 115, Ellerslie, Md. 21529			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF Arthur H. Zeigler DUE TO, OR AS A CONSEQUENCE OF Arthur H. Zeigler (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 91539			21f. LOCATION STREET 91539			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (did not) view the body after death.														
22b. SIGNATURE DR G. FISCUS			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/29/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR G. FISCUS			22e. ADDRESS Cumberland Mem. Hospital, Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/29/83			23c. NAME OF CEMETERY OR CREMATORIAL Lybarger Cemetery			23d. LOCATION CITY OR TOWN Londonderry Twp, Bedford Pa.					
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler			ADDRESS Hyndman, Pa. 15545			25a. DATE REC'D. BY REGISTRAR SEP 29 1983			25b. REGISTRAR'S SIGNATURE John C. Cawley					

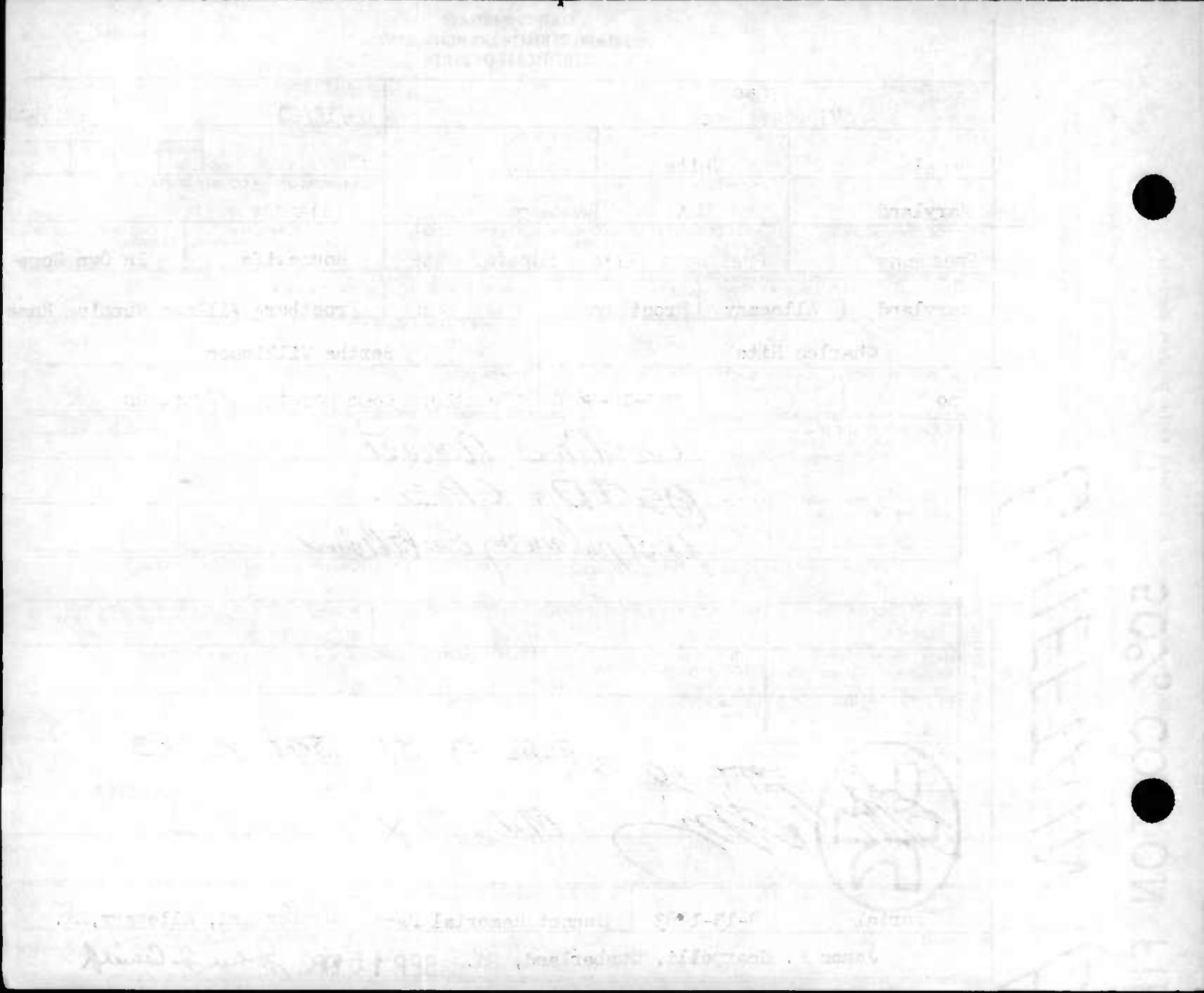


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	22913		
										REG. NO.			
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mae		MIDDLE	LAST		09/10/83		10:30 pm				
2. Virginia Mock		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female		White				10/16/05	77		YRS.				
7b. COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA				MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home		13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Frostburg Village Nursing Home		21532	
14. FATHER'S NAME FIRST Charles Hite		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Bertha Wilkinson		ADDRESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-09-9650		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
						(b) <i>PSCVD. CBS.</i>							
						(c) <i>post pulmonary embolism</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 23 1981</i> to <i>Sept 10 1983</i> , that (I) (we) last saw the deceased alive on <i>Sept 10 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John J. Conigliaro</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-13-1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conigliaro</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22914				
										REG. NO.				
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			Margaret Elizabeth Morrissey						9-17-83					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
Female			Cau.			10 06 10			72 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			USA						Alleg.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			31 Weber St.			Retired			School Cafeteria					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Alleg			Cumberland						31 Weber St 21502		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John C. Shober						Rachel Welsh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			219-03-9363			Mrs. Toby Durst, Frostburg, Md. Daughter								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>widespread metastasis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1749 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ca of breast</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD.</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>7-28 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>9-18-83</u>				
22b. SIGNATURE <i>O Melana</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John MEHANNA</i>			22e. ADDRESS <i>909 B. Setor A. Cumberland, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-20-1983			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. DATE REC'D BY FUNERAL DIRECTOR SEP 22 1983			25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>					
DHMH-16 50M 1B1 (VRA 15, 4)														

CB-TU-2 ~~residual~~ ~~standard~~ ~~calibration~~

RT C1 80 61 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22915				
1 - FOR STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		JUNE			LOUISE			PARRISH			September 17, 1983				1:15 PM	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White			Month Day Year Jan 9 1917			66			YEARS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
W.Va		USA						Allegany Co								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Cumberland		Memorial Hosp. & Medical Center						Housewife								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
W.Va		Mineral		Sulphur					99999							
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
Charles		Bebe						Martha					Harvey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
NO		235-32-7042			Elmer Parrish			Rt 1 Elk Garden, WV								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MASSIVE Myocardial Infarction</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15/83</u> to <u>9/17/83</u> , that (I) (we) last saw the deceased alive on <u>9/17/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Abdul</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9/18/83</u>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS Memorial Ave. Memorial Hosp: Medical Bldg., Cumberland, MD 21502														
Dr. N. A. Ranjithan																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIALY			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		9-19-1983			IOOF Cemetery			Elk Garden		Mineral		W. Va.				
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
David A. Burdock		Kitzmiller, Md.						SEP 29 1983		<u>John J. Conner</u>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22916	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR 8:17 AM	
GEORGE WILLIAM PRICE						September 12, 1983							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH May DAY 14 YEAR 1909			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS		
							74			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mill worker			12b. KIND OF BUSINESS OR INDUSTRY Buchanan Lumber			CUMBERLAND, MD 21502			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 321 First Ave. Triple Lakes			
14. FATHER'S NAME FIRST George MIDDLE Homer LAST Price				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Grace LAST Binnix									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			Cumberland, MD 21502			
no		214-05-6853		Pearl Price 321 First Ave. Triple Lakes									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA of prostate</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Anemia, Tachycardia; Asater</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				<input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <u>John J. Connel</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/12/83		
Dr. N.A. Ranjithan		Memorial Hosp. Med. Bldg. Cumberland, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-83		23c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Memorial P.			23d. LOCATION CITY OR TOWN La Vale			COUNTY Allegany			STATE MD
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H.		ADDRESS 21502 404 Decatur St. Cumb. MD		25a. DATE REC'D. BY REGISTRAR SEP 14 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-550-3500.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 33 22917			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 8:00			
VIRGINIA ISODORE PRYOR				SEPTEMBER 17, 1983				P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH NOV. 14, 1913 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS 0 YRS.		IF UNDER 24 HRS HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL & MED. CENTER INC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1603 Ford Ave. 21502			
14. FATHER'S NAME FIRST Benjamin H. Sirbaugh		MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Mary E. Farris		MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-9405		17. INFORMANT Mrs. Sandra Peer, Cumberland, Md. Daughter		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Adeno Carcinoma Unknown Primary								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 9/19/83			
22b. SIGNATURE 		22d. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Q. ZAMAN		23. NAME OF CEMETERY OR CREMATORIAL 24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-21-1983		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery		25a. DATE REC'D. BY REGISTRAR SEP 22 1983				25b. REGISTRAR'S SIGNATURE 	

20% COTTON

100% POLYESTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22918					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
RUTH		K.			REEL					September 27, 1983				6:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Month Day Year Jan. 12, 1916						67	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Med. Center Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Textile								
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 754 Maryland Ave. 21502					
14. FATHER'S NAME FIRST Cissel P. Kalbaugh		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST Mary Estella Allen			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-5565		17. INFORMANT Mr. Glenwood Reek, Cumberland, Md. Husband			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4590				CVA, STROKE WITH IRREVERSIBLE COMA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) HEMORRHAGIC INFARCTION, LEFT, MASSIVE													
		DUE TO, OR AS A CONSEQUENCE OF (c) COMPLETE COMPRESSION LEFT VENTRICULAR SYSTEM													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Richard Schindler		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCHINDLER		22e. ADDRESS 69 GREENE ST CUMBERLAND, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-30-1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		COUNTY STATE						
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 03 1983			25b. REGISTRAR'S SIGNATURE John Schindler							

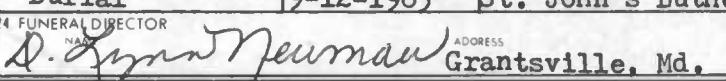
Definitions

Ward 5, W. fuscoid

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified above.

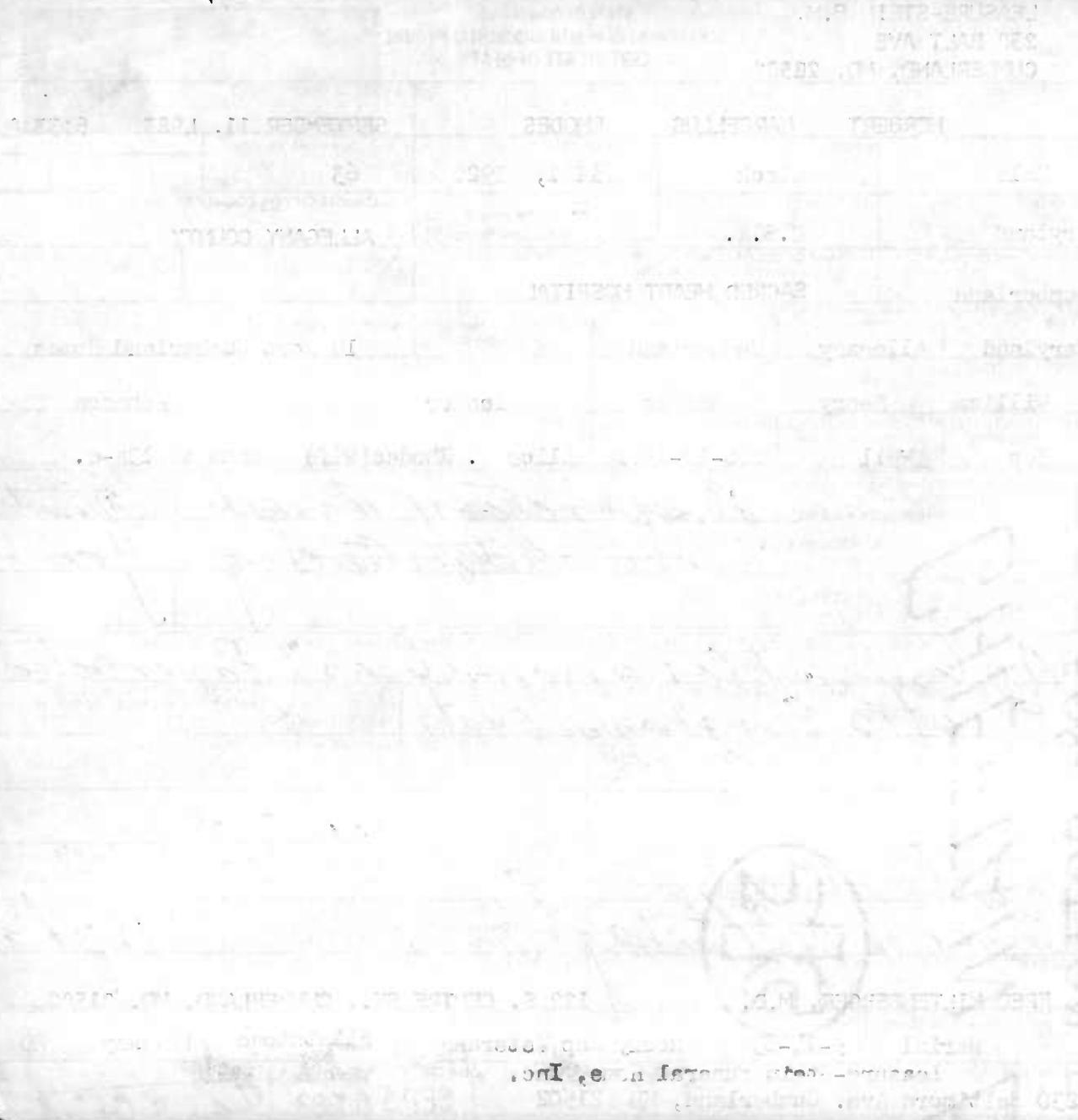
NEWMAN FUNERAL HOME P.O. BOX 267 GRANTSVILLE, MD			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			83 22919					
1. FOR STATE REGISTRAR						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ESTELLA		NMI		REICHENBECHER		SEPTEMBER	9, 1983			11:10PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 25, 1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 84		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS MONTHS DAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		MD.			
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Accident		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2, Box 68		21520	
14. FATHER'S NAME FIRST Christian		MIDDLE J.	LAST Folk	15. MOTHER'S MAIDEN NAME FIRST Elizabeth		MIDDLE	LAST Hetrick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Vernon E. Reichenbecher, Accident, Md. 21520		ADDRESS Rt. 2, Box 45		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Cardiac Failure									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148		DUE TO, OR AS A CONSEQUENCE OF (b) Ischaemic Cardiomyopathy								years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.		DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Bleeding Duodenal Ulcer CVA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE V. MAZZOCO M.D.		22e. ADDRESS 912 SETON DRIVE, CUMBERLAND MARYLAND 21502				22f. DATE SIGNED 9-11-83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-12-1983		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Lutheran cen., Accident, Garrett, Md.		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME 		ADDRESS Grantsville, Md.				25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LEASURE-STEIN F.H.			STATE OF MARYLAND			DEPARTMENT OF HEALTH AND MENTAL HYGIENE			8 3 2 2 9 2 0				
1. FOR STATE REGISTRATION 230 BALT AVE CUMBERLAND, MD. 21502						CERTIFICATE OF DEATH			REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST				2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
HERBERT MARCELLUS RHODES									SEPTEMBER 11, 1983				6:33 AM
3. SEX Male			4. RACE Black	5. DATE OF BIRTH April 1, 1920			6. AGE (IN YEARS LAST BIRTHDAY) 63			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.						
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21502			
14. FATHER'S NAME William Henry Rhodes			15. MOTHER'S MAIDEN NAME Eleanor Johnson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W11 220-10-1971A			17. INFORMANT Alice E. Rhodes (wife) same as 13a-e.			ADDRESS				
18. CAUSE OF DEATH: Enter only one cause per line for each part I and II. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5303			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive lung DUETO, OR AS A CONSEQUENCE OF (c)			Approximate Interval Between Onset and Death Minutes							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Atherosclerotic coronary disease, Pancreatic													
19a. DATE OF OPERATION 9 Sept 83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal fist.			20a. AUTOPSY? NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART I OR PART II)							
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 83</u> to <u>11 Sept 83</u> , that (I) (we) last saw the deceased alive on <u>Aug 83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.													
22d. SIGNATURE Fred Miltzenberger, M.D.			22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 15 Sept 83				
22g. PHYSICIAN'S NAME (TYPE OR PRINT)			22h. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-14-83			23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap Veterans			23d. LOCATION Flintstone			COUNTY Allegany	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc. ADDRESS 230 Baltimore Ave. Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR SEP 16 1983			25b. REGISTRAR'S SIGNATURE George Gruen				



20
10 HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and witnessed by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 should be sent within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and advised.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

83 22921

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
LEO WILLIAM RHODES, SR.						9 27 83				7:09am M		
3. SEX		RACE	5. DATE OF BIRTH			16. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		White	MONTH	DAY	YEAR	55	YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		U.S.A.					Allegany					
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumb.		Sacred Heart Hospital			Clerk (AEP) and owner (Tavern)		99999 1267531					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
W.VA.		Mineral	Ridgeley			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		57 Carpenter Ave.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS					
		Leo	Martin	Rhodes	Bertie		Rowe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes - U.S. Navy Air Corps		234-38-8389			Wilma B. Rhodes - Address same as #13 above.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac Arrest												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Myocardial infarction												
(c) Cer. heart Disease.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus. Hist. of Previous Myocardial infarction.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19 69 to Sept. 27 19 83, that (I) (we) last saw the deceased alive on Sept. 6 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) know the body after death.												
22b. SIGNATURE C. J. Vincent M.D.						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/28/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
C. J. Vincent						909-B Seton Drive - Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE	
Burial		9/29/83		Restlawn Mem'l. Gardens		Cumberland-Allegany Co., Md.						
24. FUNERAL DIRECTOR NAME		George Upchurch Funeral Home, P.A. 202 Greene Street - Cumberland, Maryland			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
					Oct 03 1983		John J. Crisler					

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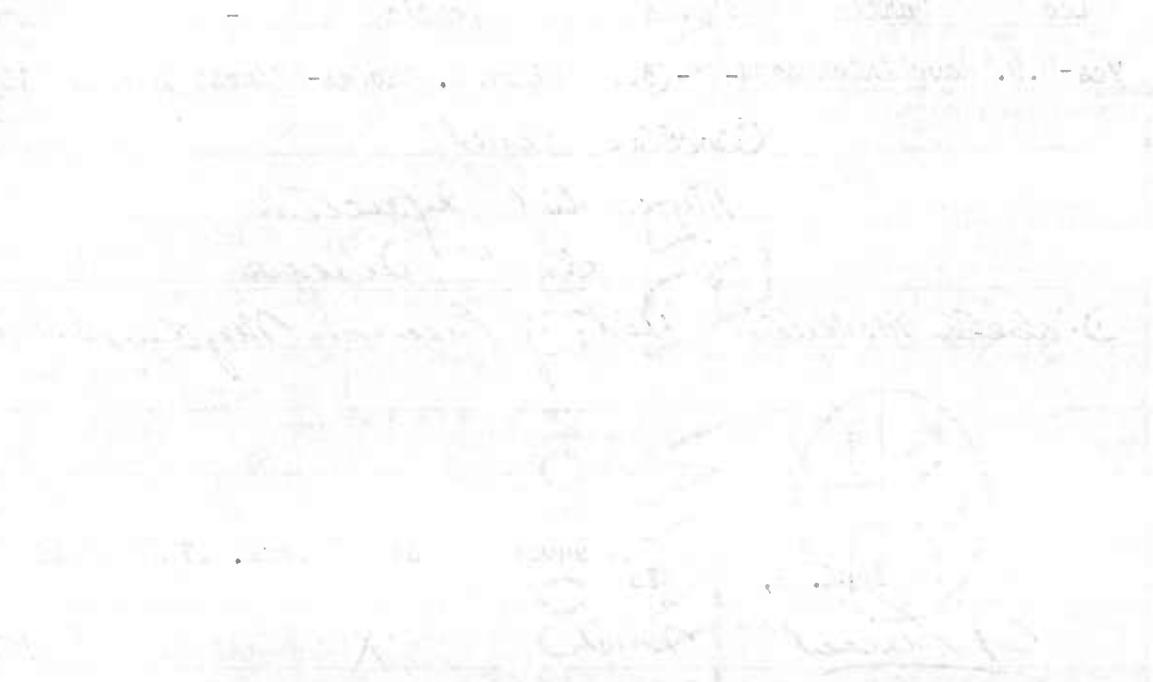
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

83 22422

Sowers Funeral Home STATE OF MARYLAND
1- STATE 60 W. Main St. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR Frostburg Md. 21532 CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
Jamie Lee Robertson								
3. SEX		4. RACE		5. DATE OF BIRTH		2d. HOUR		
MALE		WHITE		MONTH	DAY	YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
MARYLAND		U.S.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.		
CUMBERLAND		Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --- N/A		
13a. STATE MD.		13b. COUNTY ALLEGANY		13c. CITY FROSTBURG		12b. KIND OF BUSINESS OR INDUSTRY --- N/A		
14. FATHER'S NAME FIRST JAMES		MIDDLE ROBERTSON		15. MOTHER'S MAIDEN NAME FIRST JUDY		LAST SMITSKY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. N.A.		17. INFORMANT ADDRESS APT. 331, FROSTBURG, MD. 21532 MR. JAMES ROBERTSON, 316 BRADDOCK ST.,		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hour		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 7650 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Immaturity (19 wks fetus)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a 19 wks immature, Prolong rupture of membrane & maternal amnionitis								
19a. DATE OF OPERATION Sep. 20. 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Sep. 20, 1983, to Sep. 20, 1983, that (I) (we) lost saw the deceased alive on Sep. 20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Rohollah Moainie		DEGREE			22c. DATE SIGNED 9/22/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moainie, Rohollah M.D.		22e. ADDRESS 900 Seton Dr. Cumberland, md. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/23/83		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PK.		23d. LOCATION CITY OR TOWN FROSTBURG		STATE ALLEGANY MD.
24. FUNERAL DIRECTOR John J. Sowers		ADDRESS 60 W. MAIN ST.		25. DATE REC'D. BY REGISTRAR SEP 29 1983		25. REGISTRAR'S SIGNATURE John J. Sowers		
SOWERS FUNERAL HOME FROSTBURG								

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George Washington University, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DURST FUNERAL HOME FOR STATE REGISTRAR FROSTBURG MD 21532			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 3 2 2 9 2 3			
						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
GEORGE STUART ROSS				SEPTEMBER 26, 1983				9:12A M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.						
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TREAD ROOM		12b. KIND OF BUSINESS OR INDUSTRY TIRE CO.			
13a. STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 126 W. MAIN ST. 21532					
14. FATHER'S NAME FIRST J.	MIDDLE LOUIS	LAST ROSS	15. MOTHER'S MAIDEN NAME FIRST JENNY	MIDDLE		LAST STEWART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-6685	17. INFORMANT MRS. PAULINE ROSS, FROSTBURG, MD.			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
<i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cer. Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>C. Durst</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT, CLARENCE M.D.			22e. ADDRESS 909-B SETON DR. CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 29 1983	23c. NAME OF CEMETERY OR CREMATORIAL RESTLAWN CEMETERY			23d. LOCATION CITY OR TOWN LAVALE, ALLEGANY, MD.			
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.			23e. DATE RECEIVED BY REGISTRAR 00105 1983 23f. REGISTRAR'S SIGNATURE <i>John J. Durst</i>						

UNITED NETHERLANDS
22 MOST AVE.
P.O. BOX 1220

GEORGE SWIFT BOSS

WILLIAM COWAN

SACRED HEART HOSPITAL

200-B CEYLON DR. CHAMBERS, N.Y. 10036

AL CEMT, CHARGE M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22924			
												REG. NO.			
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
	PEARL			ELEANOR		ROWAN	September 27, 1983						2:34 P.M.		
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White			Month Day Year Aug. 26, 1900			83 YRS.			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Pennsylvania	USA						Allegany								
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland												31500			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland	Allegany	Cumberland						210 Grand Avenue							
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
	William	Edward	True				Martha		Garland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No	214-14-7945			Chloe Light daughter			same as 13a-e.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4148</u>															
(b) <u>HF</u>															
(c) <u>ASCVD</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>C 14 P</u>															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (1) this hospital attended the deceased from <u>9-25</u> , 19 <u>83</u> , to <u>9-27</u> , 19 <u>83</u> , that (1) we last saw the deceased alive on <u>9-27</u> , 19 <u>83</u> and that (1) my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) not view the body after death.															
22b. SIGNATURE <u>A. J. Bollino</u>	22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN	<input type="checkbox"/> MEDICAL DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22d. DATE SIGNED <u>28 Sept 83</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			955 Frederick Street Cumberland, MD 21502								
Dr. Anthony J. Bollino, Jr.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			Pennsylvania				
Burial	9-29-83	Buck Valley Meth. Cem.			Buck Valley										
24. FUNERAL DIRECTOR	Leasure-Stein Funeral Home, Inc.			NAME 230 Baltimore Ave. Cumberland, MD 21502			25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE							
BP							OCT 4 1983								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22925											
										REG. NO.											
1 - FOR STATE REGISTRAR																					
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR							
LILLIAN	HIMMLER						SELL			September 17, 1983	AUGUST	8:06	M								
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
FEMALE	WHITE			MONTH JUNE DAY 27 YEAR 1923			60 YRS.			MONTHS		DAYS HOURS MIN.									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH														
MARYLAND	USA						ALLEGANY	MD.													
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY									
CUMBERLAND	Memorial Hosp. & Medical Center										C&P TELEPHONE CO	TELEPHONE									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS															
MD.	ALLEGANY	CUMBERLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			700 LINCOLN STREET	21502														
14. FATHER'S NAME	FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME																	
EDWARD	HIMMLER			FIRST LILLIAN			LAST DUQUETTE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
NO	215-18-8922			ALBERT SELL 700 LINCOLN STREET			CUMBERLAND MARYLAND 21502														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830	Overdose of Coronary Artery Disease 1 year																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
	Nov 83	Obstetrics	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	P.M. 19																				
22a. I certify that (I) (this hospital) attended the deceased from <u>4 July 1983</u> to <u>19 Sept 83</u> , th <u>o</u> (we) last saw the deceased alive on <u>12 Sept 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE									
22b. SIGNATURE																					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)																					
Frederick W. Miltenberger, MD																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE SEPT 20 1983			23c. NAME OF CEMETERY OR CREMATORIAL ROSEDALE			23d. LOCATION CITY OR TOWN MARTINSBURG			COUNTY BERKELEY		STATE W.VA.									
24 FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD																					
SEP 21 1983																					

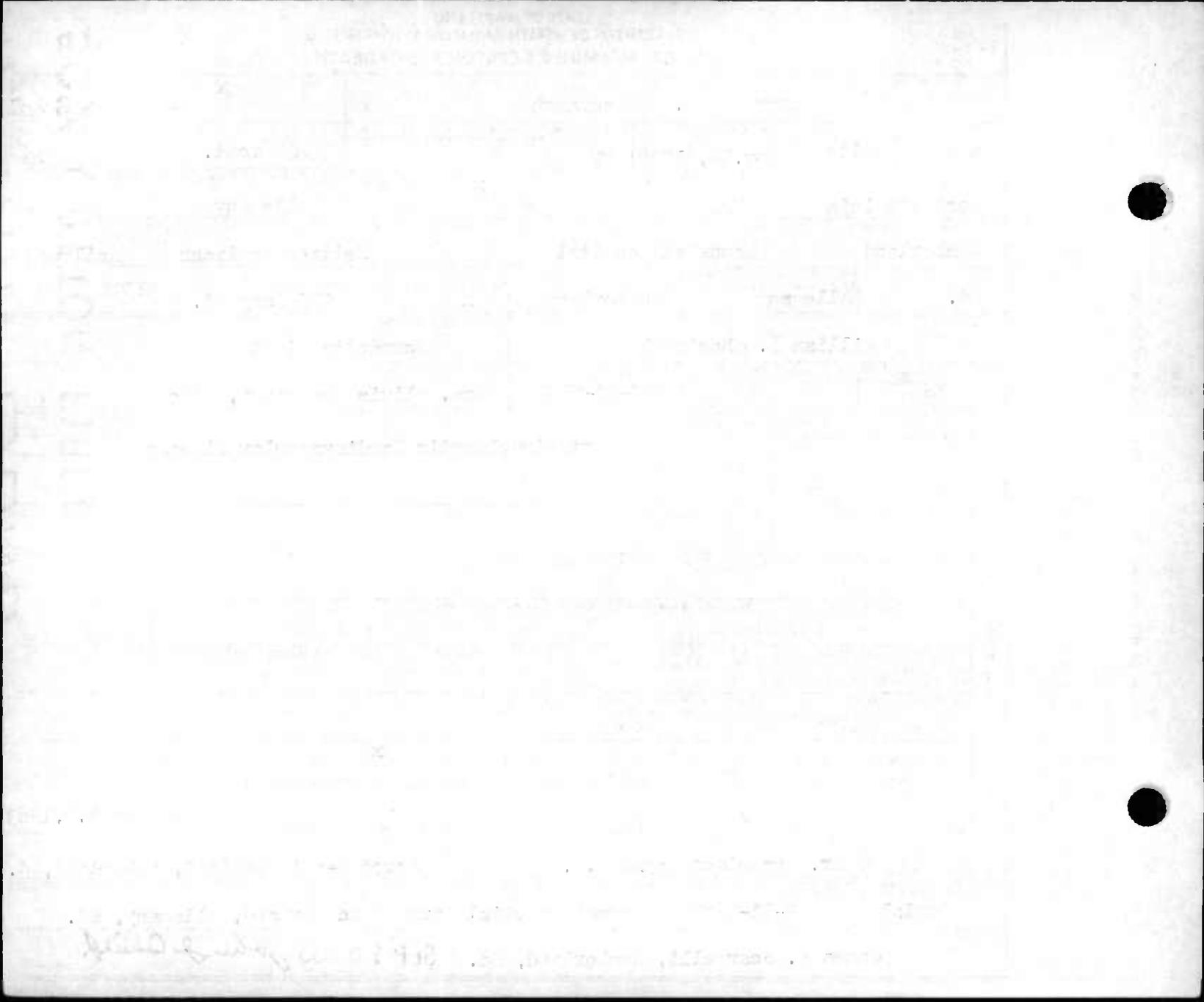


X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

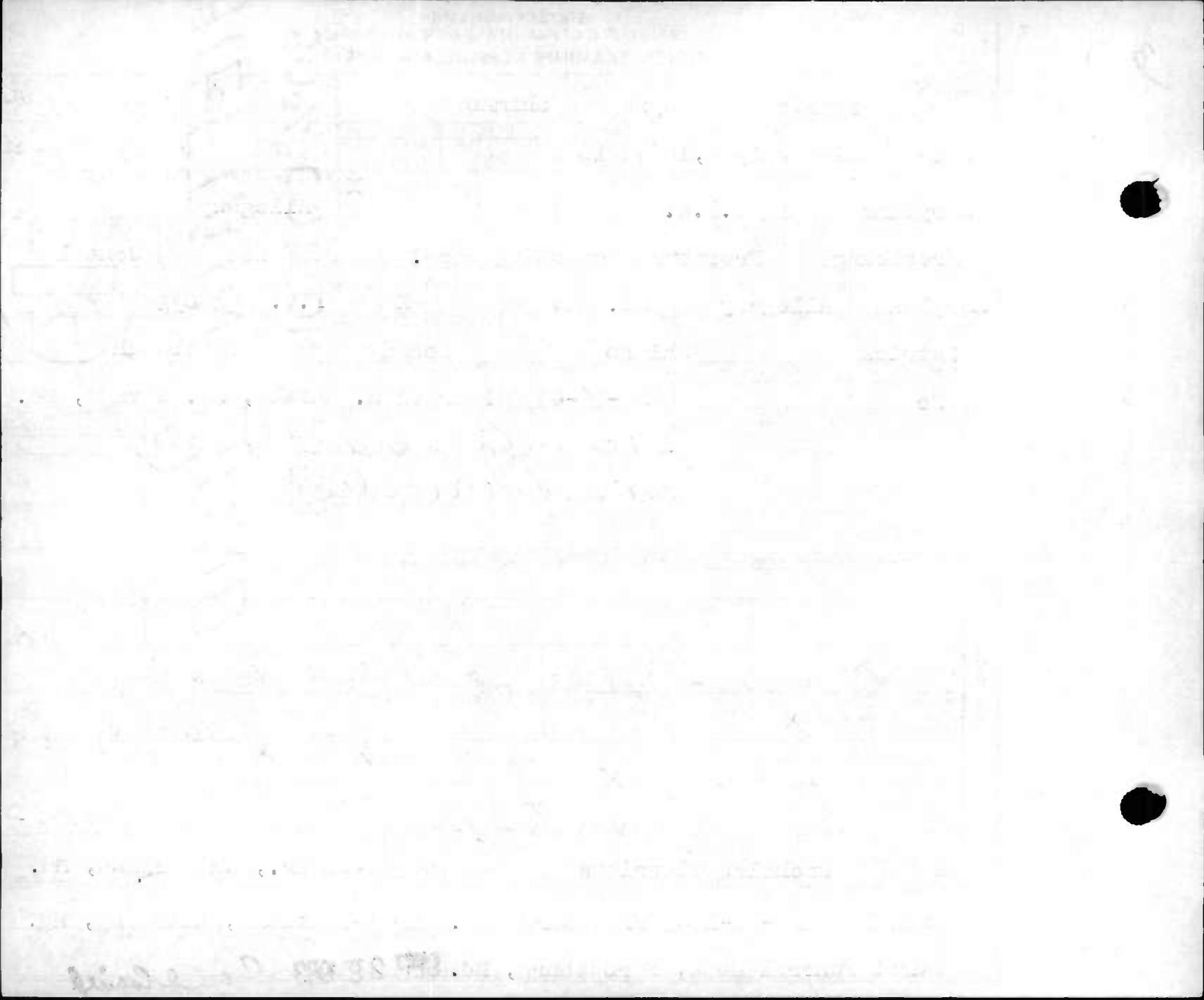
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22926
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ovey	MIDDLE E.	LAST Shambaugh	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH 9-9	DAY 1983	YEAR B 20A	2b. HOUR 3:20M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 18, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 77 yrs.	IF UNDER 1 YR. MONTHS 77	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Sept. 9 1983			2d. HOUR 3:20M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Engineer			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 Mary St.			21502	
14. FATHER'S NAME FIRST William I.		MIDDLE Shambaugh		LAST	15. MOTHER'S MAIDEN NAME FIRST Berndette		MIDDLE Light					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-05-5154		17. INFORMANT Mrs. Olivia Shambaugh, Wife		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">(b)</div> <div style="margin-left: 10px;">DUE TO, OR AS A CONSEQUENCE OF</div> </div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">(c)</div> <div style="margin-left: 10px;">DUE TO, OR AS A CONSEQUENCE OF</div> </div>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Francisco Reyes</i>		M.D.		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED Sept. 9, 1983				
EXAMINER'S NAME (TYPE OR PRINT) Dr. Francisco Reyes M.D.		ADDRESS Sacred Heart Hospital, Cumberland, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-1983		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.						
24. FUNERAL DIRECTOR NAME James F. Scarpellini		ADDRESS Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE <i>John J. O'Neill</i>						
DHMH-17 (VRA15ME(5)) 15M 2/80												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 30 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										83	22921				
										REG. NO.					
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
		Patrick Wayne Shimko						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-24	1983	12:45 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		July 8, 1967		16						9. 24 83		12:25 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frostburg		Frostburg Community Hosp.			Student			School			MD.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		91545					
Maryland		Allegany		Mt. Savage				P.O. Box 631							
14. FATHER'S NAME FIRST		Shimko			15. MOTHER'S MAIDEN NAME FIRST		Bluebaugh								
Patrick					Donna										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS								
No		215-76-0333			Patrick B. Shimko, Mt. Savage, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>8199</i> <i>Internal Intracranial Hemorrhage</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Auto-accident</i> . (c) <i>Auto-accident</i> .															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Auto accident - Head injury</i>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Ridgeview Blvd.</i>			21f. LOCATION STREET <i>Ridgeview Blvd.</i>			CITY OR TOWN <i>Bladensburg</i> COUNTY <i>Allegany</i> STATE <i>Md.</i>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE		<i>Nicholas Giarritta, M.D.</i>								TITLE (SPECIFY) <i>Deputy</i>		DATE SIGNED <i>9-24-83</i>			
EXAMINER'S NAME (TYPE OR PRINT)		Nicholas Giarritta								ADDRESS 900 Seton Dr., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Burial		9-26-1983		Frostburg Mem. Park			Frostburg, Allegany, Md.			Sep 28 1983		See attached			
24. FUNERAL DIRECTOR NAME		ADDRESS													
Durst Funeral Home, Frostburg, Md.															
DHMH-17 (VR A15 ME (5)) TSM 2/80															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SCARPELLI FUNERAL HOME 108 VIRGINIA AVENUE CUMBERLAND, MD 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			83 22928		
1. DECEASED NAME (TYPE OR PRINT)			LAST			REG. NO.		
FRANCES LOUISE SHINSKY								
2. DATE OF DEATH			MONTH DAY YEAR			26 HOUR		
SEPTEMBER 6, 1983			5:28A M					
3. SEX			4. RACE			5. DATE OF BIRTH		
Female			Cauc.			MONTH DAY YEAR		
2/26/01								
6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
82 YRS.			MONTHS DAYS			HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Pa.			USA					
9. BALTIMORE CITY OR COUNTY OF DEATH						MD.		
ALLEGANY COUNTY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland			SACRED HEART HOSPITAL			housewife		
13a. STATE			13b. COUNTY			13c. CITY, OR TOWN		
Md.			Allegany			Cumberland		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY		
			812 Highland Ave. 21502			-		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST			FIRST MIDDLE LAST					
Unknown			Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			213-74-7596			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Pulmonary edema								
2500 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) CHT -					
			DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes x Hyper tension					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-1, 1983, to 9-6, 1983, that (I) (we) last saw the deceased alive on 9-5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE			DEON ALICE M			22c. DATE SIGNED		
						9-6-83.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
URIEL VELANDIA, M.D.			924 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL		
Burial			9/10/83			Gardens of Faith		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		
Schimunek Funeral Home, Inc.						25b. REGISTRAR'S SIGNATURE		
3331 Brehms Lane, Balto., Md.						SEP 9 1983 John & Carol		
BP _____			21213					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
JOHN HENDERSON FUNERAL HOME 215 CENTRAL AVE. JOHNSTOWN, PA. 15902			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 3 22929		
2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ROBERT DAVID SNYDER			SEPTEMBER 1, 1983			7:10 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		
Male		White		10	18	16	66	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Machinist Celanese Fibers Corp		
13a. STATE Maryland		13b. COUNTY Allegheny		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		MD.
14. FATHER'S NAME FIRST George		MIDDLE Snyder		LAST Snyder		15. MOTHER'S MAIDEN NAME FIRST Sarah		LAST Blough
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Mildred Snyder Rt 6 Box 233		ADDRESS Cumberland Md		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure + Infarct APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma & Multiple Metastasis; Stroke (c) Advanced Carcinoma of Prostate, advanced								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8/11/83		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		8/11/83		
22a. I certify that (I) (this hospital) attended the deceased from 8/11/83 to 8/11/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCHINDLER E., M.D.		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9-2-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/6/83		23c. NAME OF CEMETERY OR CREMATORIAL Forest Lawn Cemetery		23d. LOCATION CITY OR TOWN Johnstown Cambria, Penna.		
24. FUNERAL DIRECTOR NAME John Henderson Co 215 Central Ave Johnstown Pa.		25a. ADDRESS		25b. DATE REC'D. BY REGISTRAR AND REGISTRAR SIGNATURE SEP 14 1983				

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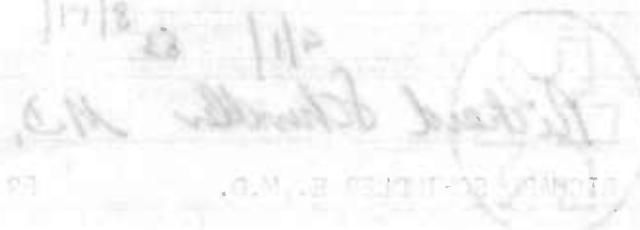
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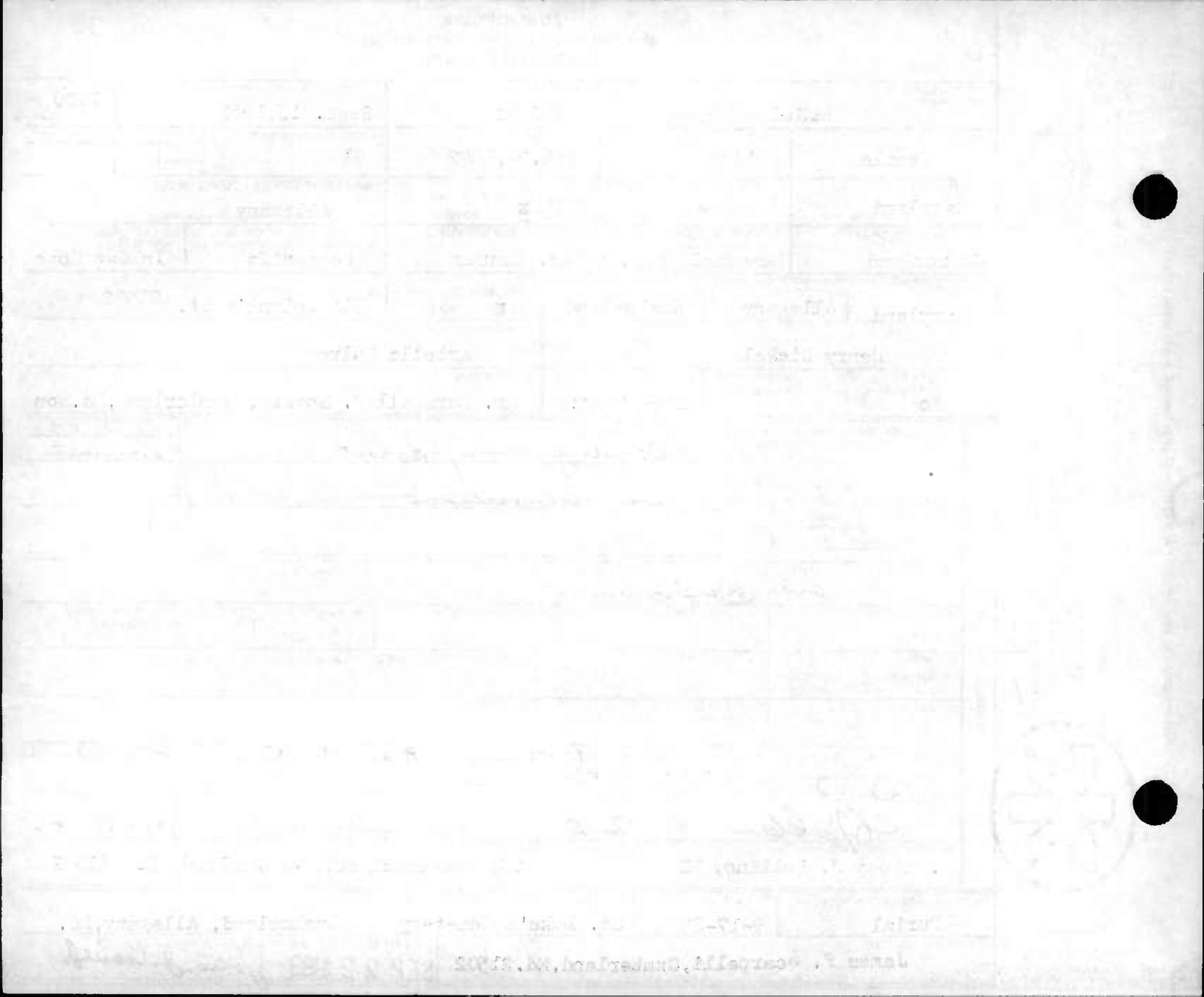
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	22930							
												REG. NO.								
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			ELSIE MAE SOWERS												Sept. 15, 1983			7:30 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
Female			White			Feb. 24, 1892			91			MONTHS DAYS			HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			MD.					
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS			13b. KODAK					
Cumberland			Memorial Hosp. & Med. Center			Housewife			In Own Home			316 Columbia St. 21502								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			13f. KODAK					
Maryland			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			316 Columbia St. 21502								
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST					
			Henry Nickel						Arbella Gulrey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			214-74-6922			Mr. Marshall H. Sowers, Cumberland, Md. Son														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Condylopalmoing arrest</i>																				
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						(b) <i>Dr. atresobose</i>														
						(c) <i>poor RBC pneumonia</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
19b.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a.			P.M. 19			21c.		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (1) (is hospital) attended the deceased from 7-14, 19 83, to 7-15, 19 83, that (we) last saw the deceased alive on 9-14 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Bollino</i>			20			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-15-83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony J. Bollino, MD			22e. ADDRESS 955 Frederick St., Cumberland, MD 21502																	
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE Burial 9-17-83			23c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502			25a. DATE REC'D. BY REGISTRAR SEP 22 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Connelly</i>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

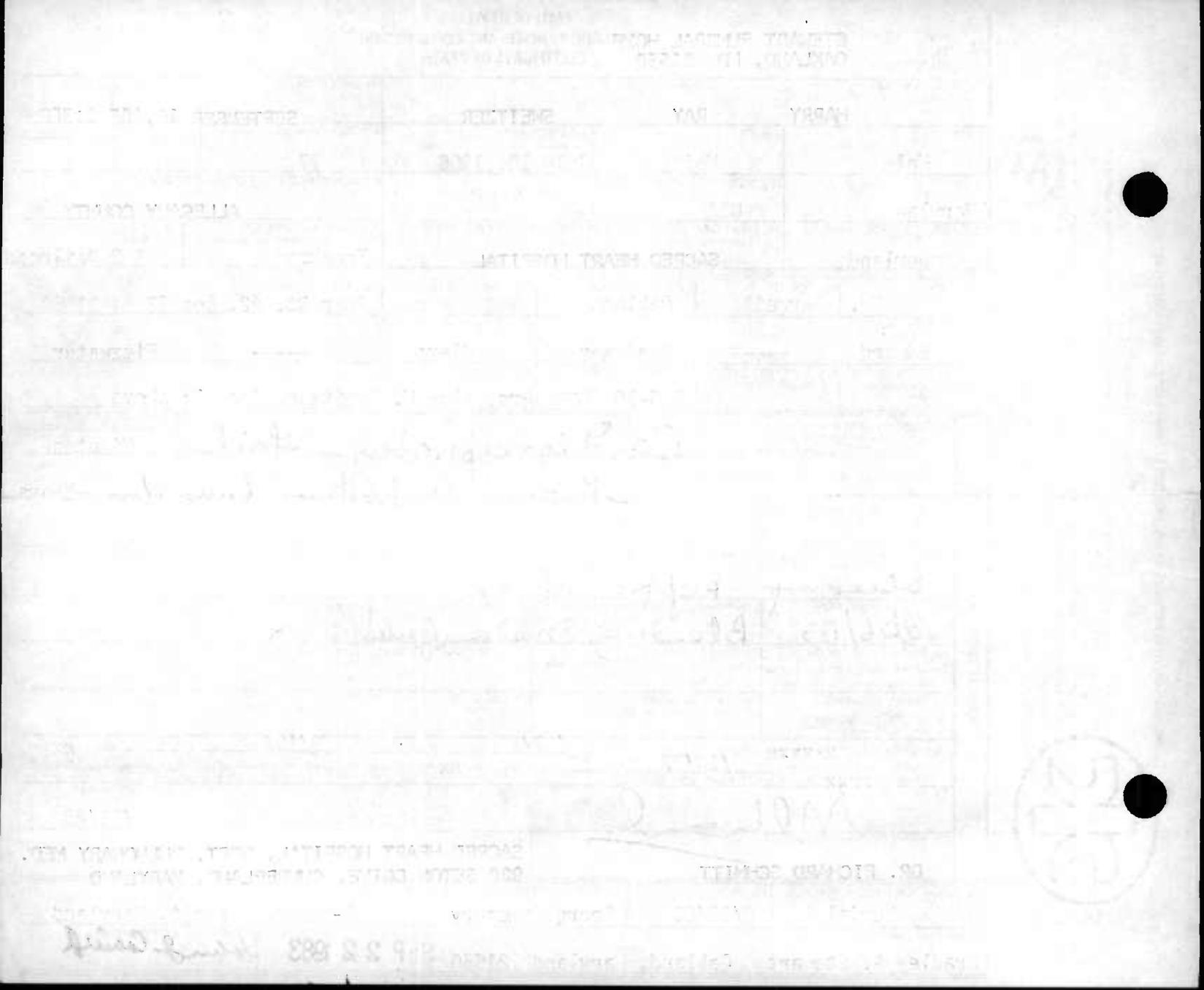
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8322931				
FOR STATE REGISTRAR			HAFER FUNERAL HOME 1302 NATIONAL HWY LAVAL E MD 21502			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
LAWRENCE NMI STRICKLAND						SEPTEMBER 28, 1983						10:20AM		
1. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White		MONTH 10 DAY 03 YEAR 11		<input checked="" type="checkbox"/> 71			MONTHS	YEARS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA				ALLEGANY COUNTY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland			SACRED HEART HOSPITAL		Retired		Textile							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland			Allegany		Cresaptown				P.O. Box 5032			21502		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
Harry					Strickland	Bertha				Kaefer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes			WW II		214 07 3643		Margaret L. Strickland - as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Tachycardia</i>														
2754 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypercalcemia</i> <i>Angophoria</i> DUE TO, OR AS A CONSEQUENCE OF (c)										2 mo				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Malay</i> <i>Tuberculosis - Arrested</i>										6 mo				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-28</i> , 19 <i>83</i> , to <i>9-28</i> , 19 <i>83</i> , that (we) last saw the deceased alive on <i>9-28</i> , 19 <i>83</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>L. M. Glick</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9-29-83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. M. Glick</i> <i>MD</i>			22e. ADDRESS <i>BMG-912 SETON DR. CUMBERLAND, MD. 21502</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>10/1/83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Lawn Mem Gar.</i>			23d. LOCATION CITY OF TOWN <i>LaVal e, Allegany, MD</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 3 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>
24. FUNERAL DIRECTOR NAME <i>John J. Hafer, Jr.</i>			ADDRESS <i>LaVal e, MD</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE OAKLAND, MD 21550 CERTIFICATE OF DEATH						8 3 2 2 9 3 2	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2d. DATE OF DEATH MONTH DAY YEAR			REG. NO.
HARRY RAY SWEITZER							SEPTEMBER 10, 1983 2:36PM			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			White	July 10, 1906		77 YRS.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA			ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland			SACRED HEART HOSPITAL						Trackman	
13a. STATE Md.			13c. CITY OR TOWN Garrett	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Star Rt. #2, Box 23			12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
14. FATHER'S NAME Edward			Sweitzer	15. MOTHER'S MAIDEN NAME Clara		LAST			Fitzwater	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Mrs. Alta M. Sweitzer, See #13 above			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
No			705-10-9038							Chronic respiratory failure Years
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic destructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bleeding peptic ulcer</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bleeding peptic ulcer</u>										
19a. DATE OF OPERATION 8/26/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding peptic ulcer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <u>XXXXXX</u> attended the deceased from 8/21/83, 19 83, to 9/10/1983, 1983, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 9/10/83, 19 83, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <u>MOL</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/11/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RICHARD SCHMITT			22e. ADDRESS SACRED HEART HOSPITAL, DEPT. PULMONARY MED. 900 SETON DRIVE, CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/13/83	23c. NAME OF CEMETERY OR CREMATORIAL Georg Cemetery			23d. LOCATION CITY OR TOWN Swanton, Garrett, Maryland			
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550	25a. DATE REC'D. BY REGISTRAR SEP 22 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conwell</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

KIGHT FUNERAL HOME
309 DECATUR ST.
CUMBERLAND, MD. 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

83 22933

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
GEORGIA COOPER SYKES						SEPTEMBER 24, 1983				3:00P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR March 26, 1903		80		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA				ALLEGANY COUNTY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Cumberland		SACRED HEART HOSPITAL		Retired		Retail Clothing					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Cumberland				123 Columbia St. 21502			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
Hiran		H.		Cooper	Katie				Fiedner		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
no		213-22-3675		Julia Ann Myerly, Cumberland, Md. 21502							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA											
4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Ascvd											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 1970, 19, to 9-24, 1983, that (I) (we) last saw the deceased alive on 9-23, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Linda Glick MD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		BMG-912 SETON DR. CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Sept. 27, 88 Indian Mound				Romney, Hampshire, West VA.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William G. Kight, Cumberland, Md.				OCT 3 1983		<i>John G. Kight</i>					

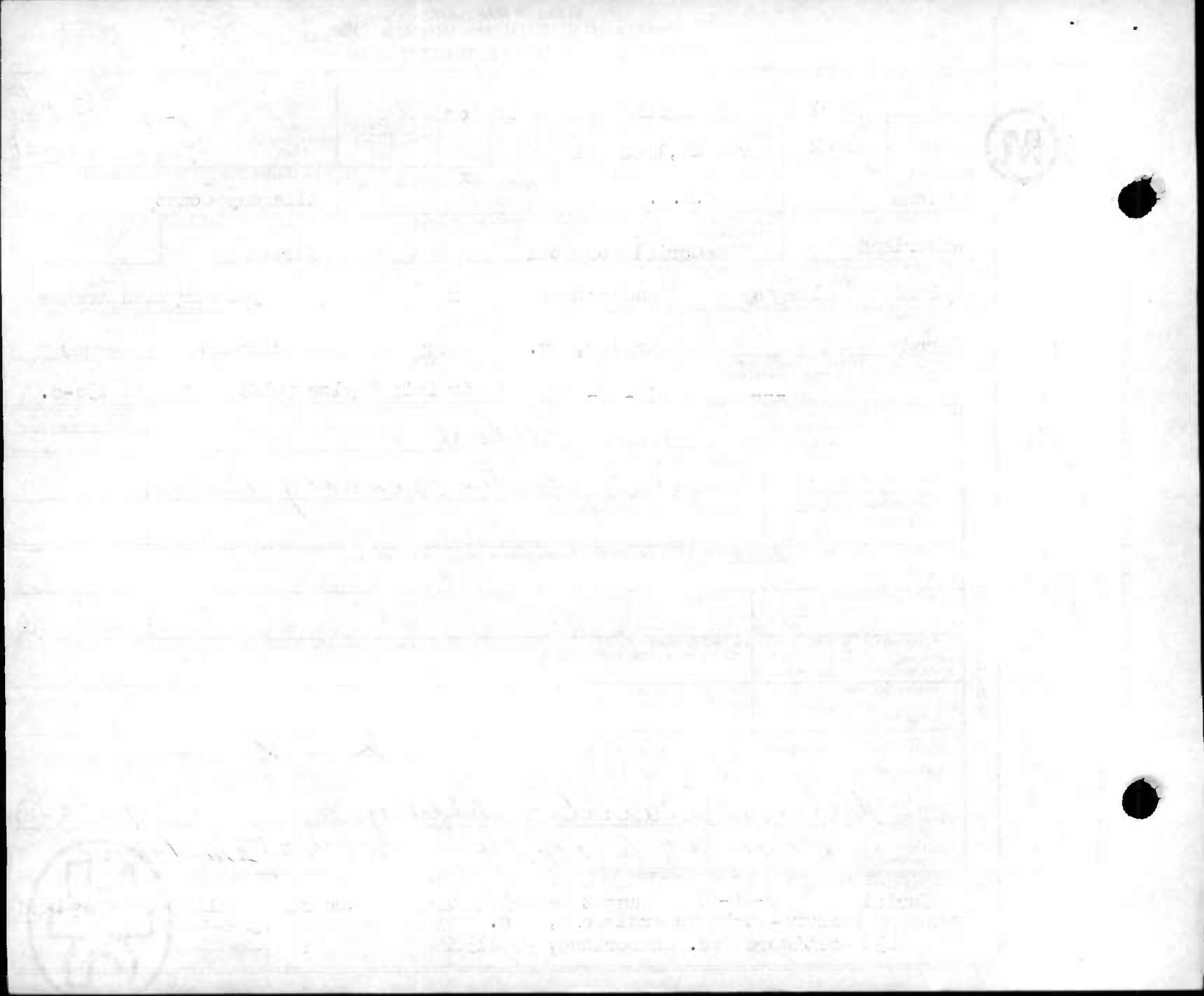
1981-01-04 00000000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22934								
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR 100 ^P	
		Carl Leslie Taylor										9-23		19	83	100 ^M		
SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH		YEAR		2d. HOUR 200 ^P
Male		Black		April 20, 1902		81 yrs.						9-23		1983		200 ^M		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County						
Maryland																		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Cumberland								Railroad										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21503								
Maryland		Allegany		Cumberland				502 Maryland Avenue										
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST								
Jerome				Taylor, Sr.		Mary		Elizabeth		Jones								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS										
(If Yes, give war or dates)		213-10-9884				Virginia Taylor (wife)		same as 13a-e.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		4140				IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
						{ (b) Arterio sclerotic coronary Disease DUE TO, OR AS A CONSEQUENCE OF												
						(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?												
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
		19																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																		
ACTUAL SIGNATURE		Nicholas Giarrita M.D. Deputy MEDICAL EXAMINER								DATE SIGNED		9-23-83						
EXAMINER'S NAME (TYPE OR PRINT)										NICHOLAS GIARRITA ADDRESS 900 SETON DRIVE								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE								
Burial		9-26-83		Sunset Memorial Park		Cumberland		Allegany		Maryland								
24. FUNERAL DIRECTOR		Leasure-Stein Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
NAME		230 Baltimore Ave.				ADDRESS		MD 21502		SEP 27 1983								

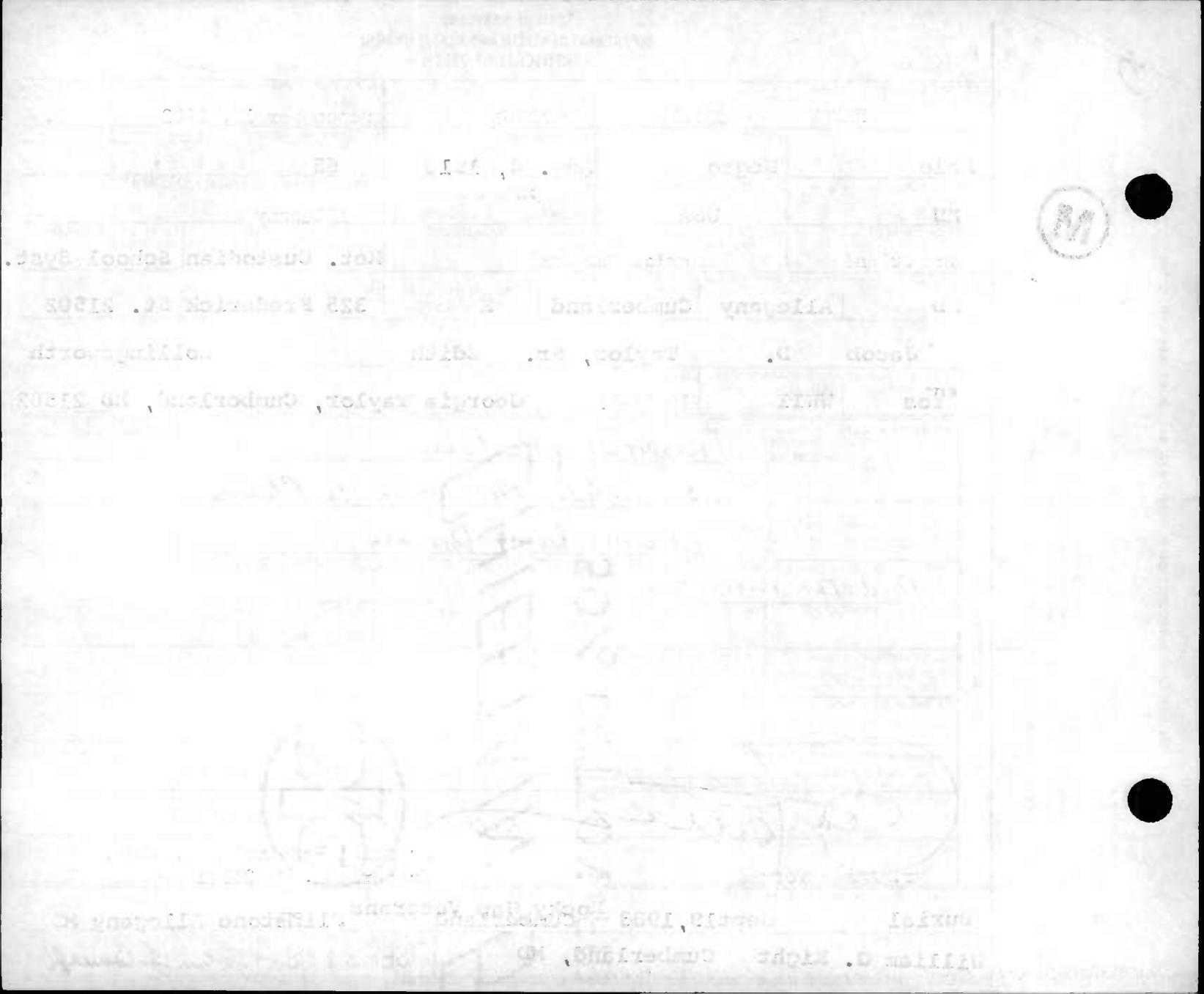


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	22935		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HENRY JOSEPH TAYLOR						September 15, 1983						4:50	
3. SEX			4. RACE			5. DATE OF BIRTH							
Male			Negro			MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			IF UNDER 1 YEAR				
MD			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Memorial Hospital			Ret. Custodian			School Syst.			MD.	
13a. STATE MD			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 325 Frederick St. 21502	
14. FATHER'S NAME FIRST Jacob			MIDDLE D.			LAST Taylor, Sr.			15. MOTHER'S MAIDEN NAME FIRST Edith			MIDDLE LAST Hollingsworth	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII			16c. INFORMANT ADDRESS							
16d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
16e. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma to Pleura										
			DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lung Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes mellitus													
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c PART II)							
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALONE <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (i) this hospital attended the deceased from _____ 19_____ to _____ 19_____, that (ii) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (I did not) view the body after death.													
22b. SIGNATURE <i>Amado Torres</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED SEP 21 1983				
22f. PHYSICIAN'S NAME (THE CERTIFYING) Dr. Amado Torres			22g. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 19, 1983			23c. NAME OF CEMETERY OR CREMATORIUM Rocky Gap Cemetery			23d. LOCATION CITY OR TOWN Flinstone			COUNTY	STATE
24 FUNERAL DIRECTOR William G. Kight			25a. DATE REC'D. BY REGISTRAR SEP 21 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Canfield</i>							
BP _____			Cumberland, MD										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	2	2	9	3	6														
												REG. NO.																				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
			RALPH			IRVIN						TEWELL			September 11, 1983						9:25 AM											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. MARRIED MONTH DAY YEAR			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Male			White			Sept. 16, 1918			64			Pennsylvania			<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany			CUMBERLAND			MEMORIAL HOSPITAL			Ret. Inspector			State Highway		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Maryland			Allegany			Cumberland			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			604 Shriver Ave. 21502			Irvin			Bertha			W.W. 11			705-05-5206			LaVerne Tewell, Cumberland, Md. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)																					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1539			Cerebrovascular accident			Cerebral hemorrhage																										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																							
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
			P.M. 19																													
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 11</u> , 19 <u>83</u> , to <u>Sept. 14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept. 11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED														
Dr. WILLIAM JAMES																											9/12/83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Burial			Sept. 14, 83			Sunset Memorial Pk.			Cumberland, Allegany, MD.									SEP 15 1983														
24. FUNERAL DIRECTOR NAME			William G. Kight, Cumberland, Md.																													

800

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22931
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		PEARL FIRST PEARL		MIDDLE VIRGINIA		LAST TOMLINSON		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 9/28	DAY 1983	YEAR 7:50 P.M.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH FEB 29 1940		6. AGE (IN YEARS) 43 (ASA BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 510 BALTIMORE AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 510 BALTIMORE AVE.		MD. 21502		
14. FATHER'S NAME FIRST HOWARD		MIDDLE C.		LAST WAGNER		15. MOTHER'S MAIDEN NAME FIRST LOUELLA		MIDDLE		LAST MERRITT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-38-5386		16c. ADDRESS CUMBERLAND, MD 21502		17. INFORMANT WILLIAM C. TOMLINSON		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND TO MOUTH, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) SELF INFILCTED DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Dr. Giovanni Mastrangelo</i>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED SEPT 29, 1983						
EXAMINER'S NAME (TYPE OR PRINT)		DR. GIOVANNI MASTRANGELO		ADDRESS SACRED HEART HOSPITAL CUMBERLAND MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT 3, 1983		23c. NAME OF CEMETERY OR CREMATORIAL ROSEDALE CREMATORIAL		23d. LOCATION CITY OR TOWN MARTINSBURG BERKELEY W.VA.						
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 03 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>						
BP		DHMH-17 (VR A15 ME (5)) 15M 2/80										

Not in use

Jan 39

1939 - 1st week December

50% full

water level

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

GEORGE-UPCHURCH FUNERAL HOME 202 GREEN STREET CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 22 938					
1 - FOR STATE REGISTRAR								REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST					2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
IRVIN ROY TWIGG									SEPTEMBER	9,	1983	1:00A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 2, 1905		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
						78		MONTHS		DAYS			
7a. BIRTHPLACE MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker-Coning Dept.-Celanese				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 202 Wills Creek Ave. (21502)					
14. FATHER'S NAME Raleigh		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Naomi		FIRST	MIDDLE	16. (LAST) (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-5468		17. INFORMANT Helen Twigg		ADDRESS Same as #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic CV Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ DUE TO, OR AS A CONSEQUENCE OF (b) with Congestive Failure { DUE TO, OR AS A CONSEQUENCE OF (c)								7 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Paralytic Illness													
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-27 , 19 83 , to 9-9 , 19 83 , that (I) (we) last saw the deceased alive on 9-9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE L. Michael Glick, M.D.		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-14-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. MICHAEL GLICK, M.D.		22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 10, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Pk.		23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE Md.			
24. FUNERAL DIRECTOR NAME George-Upchurch Fun'l. Home		25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield									

YOUNG MINNIE

SCOTTISH HORN

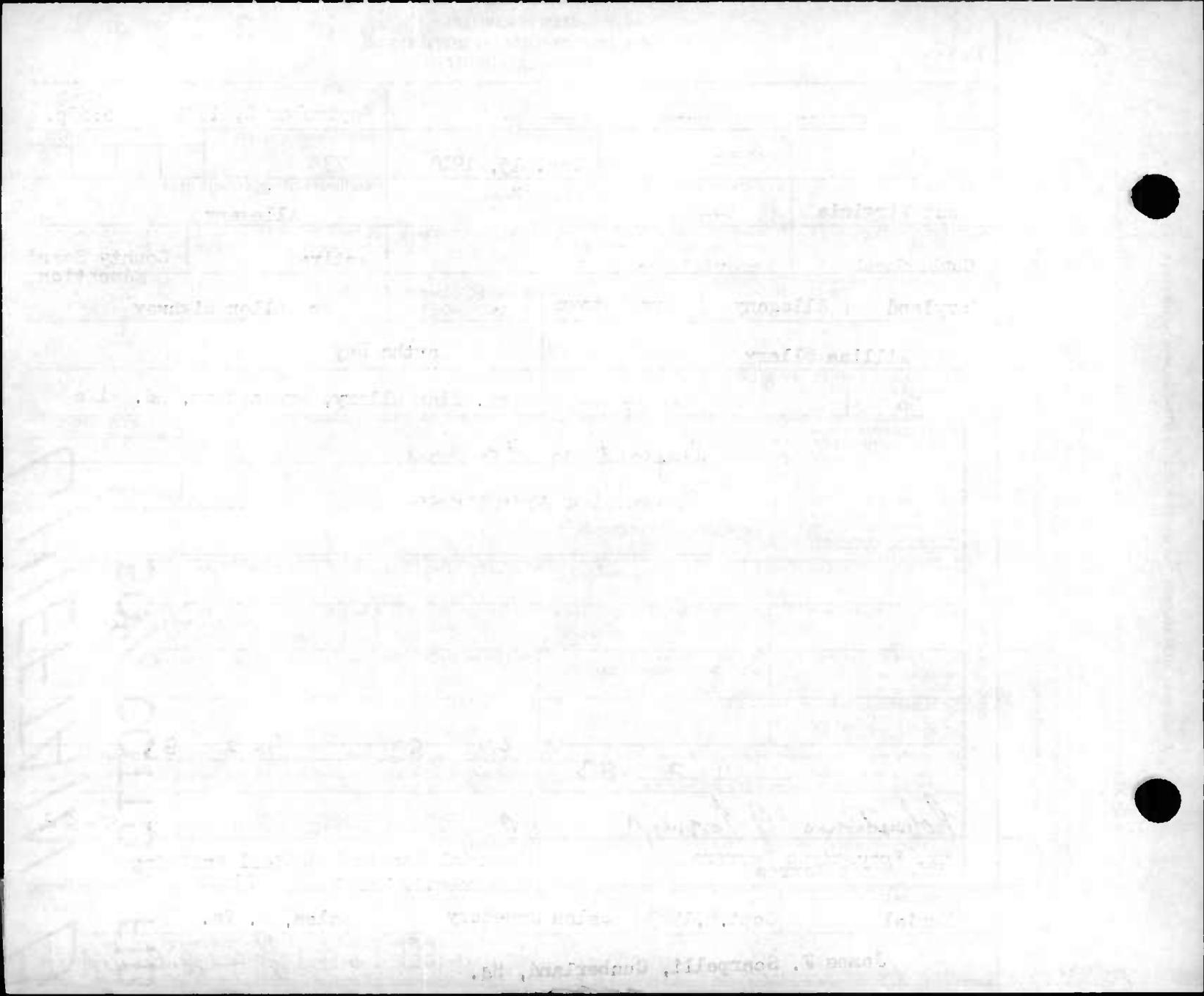
100-101-102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 22939								
										REG. NO.								
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			September 2, 1983 5:55p.m.												
ERNEST ARMEL ULLERY																		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		Jan. 15, 1910			73		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.											
West Virginia		USA																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Memorial Hospital							Retired		County Board Education							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ADDRESS							
Maryland		Allegany		Cresaptown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Mc Mullen Highway		81002							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																
William Ullery		Martha Day																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ilda Ullery, Cresaptown, Md. Wife														
No		214-07-4984																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchitis pneumonia</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 8-8 19 83 to 9-2 19 83, that (I) (we) last saw the deceased alive on 9-2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Robustiano J. Barrera</u>			DEGREE MD							ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robustiano Barrera Dr. Amado Torres			22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 6, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Salem Cemetery				23d. LOCATION CITY OR TOWN Salem, W. Va.		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			25. DATE REC'D. BY REGISTRAR SEP 13 1983							26. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be delivered for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, or cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	22940		
										REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			ELMER			VANPELT			09 12 83			9:00a.m.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE			WHITE			8 09 1892			91 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
WV			USA						ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND			MEMORIAL HOSPITAL										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
MD			ALLEGANY			CUMBERLAND						217 Maryland Ave. 21562	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
CHARLES VAN PELT			AMANDA SAVILLE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
						DON VAN PELT			HANOVER, PA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4860</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Septicemia</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>? pneumonia. ? skin infection</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Respiratory failure, Acidosis, old age.</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <i>N.B. Ranjithan</i>			22c. DEGREE <i>MD.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>9/12/83</i>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/15/83			23c. NAME OF CEMETERY OR CREMATORIAL <i>Philos Cemetery</i>			23d. LOCATION CITY OR TOWN WESTERNPORT COUNTY ALLEGANY STATE				
24. FUNERAL DIRECTOR <i>Magnusson</i>			25a. DATE REC'D. BY REGISTRAR SEP 19 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Clark</i>							
BOALS FUNERAL SERVICE WESTERNPORT, MD.													

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JATTESON JAMES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DURST FUNERAL HOME			STATE OF MARYLAND			DEPARTMENT OF HEALTH AND MENTAL HYGIENE			CERTIFICATE OF DEATH			REG. NO. 83 22941		
1 - FOR STATE REGISTRAR FROSTBURG MARYLAND 21532														
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
HAROLD ENLOW WAMPLER									SEPTEMBER 10, 1983			10:47P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
MALE			WHITE			MAY 3, 1912			71 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION CO					
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN LA VALE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1135 BRADDOCK ROAD		
14. FATHER'S NAME FIRST WILLIAM			MIDDLE LAST WAMPLER			15. MOTHER'S MAIDEN NAME FIRST MARY			16. SOCIAL SECURITY NO. 212-10-6325			17. INFORMANT ADDRESS MR. DONALD HAHN, RAWLINGS, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pneumonia			DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Sept 10, 1983			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Sept 10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			22b. DATE SIGNED 8-12-83											
22c. SIGNATURE CHANG OH M.D.			22d. DEGREE M.D.			22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22f. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH M.D.			22g. ADDRESS 48 TARN TERRACE FROSTBURG, MARYLAND 21532											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 13, 1983			23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION CEMETERY			23d. LOCATION CITY TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD. 21532			ADDRESS						25a. DATE REC'D. BY REGISTRAR SEP 19 1983			25b. REGISTRAR'S SIGNATURE		

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FRUITLAND, IDAHO - 1. 1951. 50000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY PERTINENT INFORMATION IS NOT KNOWN, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. RETAIN PAGES 1, 2, AND 3 FOR THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGES 1, 2, AND 3 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22942		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR 3:30 a.m.
Gladys Carrie Whalley							IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)									2c. DATE PRONOUNCED DEAD		
Female	White	Aug 14 1904	79 yrs.									9 17 1983 8:20 a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		129 East Elder Street					Employee				Dept Store			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 129 East Elder Street						
14. FATHER'S NAME FIRST Owen		MIDDLE W		LAST Zimmerly		15. MOTHER'S MAIDEN NAME FIRST Anna		MIDDLE Margaret		LAST Bloss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			190-44-9841			Mrs. Margaret P. Smith			129 E. Elder Street Cumberland, Md 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p style="margin-left: 40px;"><i>4140</i></p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.</p> <p style="margin-left: 40px;">(b) _____</p> <p style="margin-left: 40px;">DUE TO, OR AS A CONSEQUENCE OF</p> <p style="margin-left: 40px;">(c) _____</p> <p style="margin-left: 40px;">DUE TO, OR AS A CONSEQUENCE OF</p>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
MALNUTRITION SECONDARY TO CHRONIC BRAIN SYNDROME														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i> M.D. Deputy MEDICAL EXAMINER</p>												TITLE (SPECIFY)		
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.												DATE SIGNED 9/17/83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Sept 20, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____					
24 FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service			ADDRESS Cumberland, Md			25a. DATE REC'D. BY REGISTRAR SEP 20 1983			REGISTRAR'S SIGNATURE <i>John J. Cawley</i>					
BP _____														
DHMH-17 (VR A15 ME (5))														
15M 2/80														

Woodbury 6805 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
retdained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 22943	
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
DENVER			ARTHUR	WILLIAMS		SEPTEMBER 1, 1983						7:40 PM	
3. SEX MALE			RACE WHITE	5. DATE OF BIRTH MONTH 3 DAY 7 YEAR 1912			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Labor			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 25 West First St. 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Ira H. Williams, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna B. Phillips							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 236-12-0727			17. INFORMANT Mr. Paul E. Williams, Flintstone, Md. Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from 9-1-1983 to 7-1-1983, that (II) we last saw the deceased alive on 9-1-1983, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)												22c. DATE SIGNED 9-1-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY BOLLINO			22e. ADDRESS 955 FREDERICK STREET CUMBERLAND, MD 21502			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-4-1983			23c. NAME OF CEMETERY OR CREMATORIAL Potomac Memorial Gardens			23d. LOCATION CITY OR TOWN Keyser, W. Va. COUNTY STATE				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.						25a. DATE REC'D. BY REGISTRAR SEP 9 1983			25b. REGISTRAR'S SIGNATURE J. Scarpelli				



2000 OCT 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MARKWOOD FUNERAL HOME 11 MINERAL STREET KEYSER WEST VIRGINIA				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 22944			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				REG. NO.			
EDNA KATHERINE WILT				SEPTEMBER 10, 1983				3:25 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 24, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGHENY COUNTY					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 39½ N. F. St.		13f. ADDRESS 99999	
14. FATHER'S NAME Archibald		MIDDLE Wilt		15. MOTHER'S MAIDEN NAME Grace							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		16c. INFORMANT Mrs. Ida M. Bodkin, Rte 3, Box 50, Rawlings, Md.		16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs					
18. CAUSE OF DEATH (Enter only one cause per line 18(a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>83</u> , to <u>9-10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul Spiggle MD</u>		22c. DEGREE				22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>9-10-83</u>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE SPIGGLE M.D.		22g. ADDRESS 912 SETON DRIVE, CUMBERLAND MARYLAND 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 12, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Queens Point Cemetery		23d. LOCATION CITY OR TOWN Keyser		23e. COUNTY Mineral		23f. STATE W.Va.	
24. FUNERAL DIRECTOR NAME Markwood Funeral Home, 111 S. Mineral St, W.Va.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Coughlin</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8322945		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
CORNELIA CLARK WOLFE						September 13, 1983						12:26 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Female			White			MONTH 05 DAY 04 YEAR 99			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Retailing					
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN LaVale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 64 LaVale Court 21502		
14. FATHER'S NAME FIRST Issac MIDDLE Frank LAST Clark						15. MOTHER'S MAIDEN NAME Julia Miller								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-24-0380			17. INFORMANT Mrs. Genevieve Twigg - same as above			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Conductive myocardial infarction</i> 2 days (c) <i>Advanced atherosclerosis</i> 7 years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-11, 1983, to 9-13, 1983, that (I) (we) last saw the deceased alive on 9-13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/14/83		
22b. SIGNATURE <i>William P. James</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William P. James			22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/16/83			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial			23d. LOCATION CITY OR TOWN Cumberland, MD 21502 COUNTY Alleg., MD STATE					
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.			ADDRESS LaVale, MD			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 16 1983 <i>John J. Hafer, Jr.</i>								

